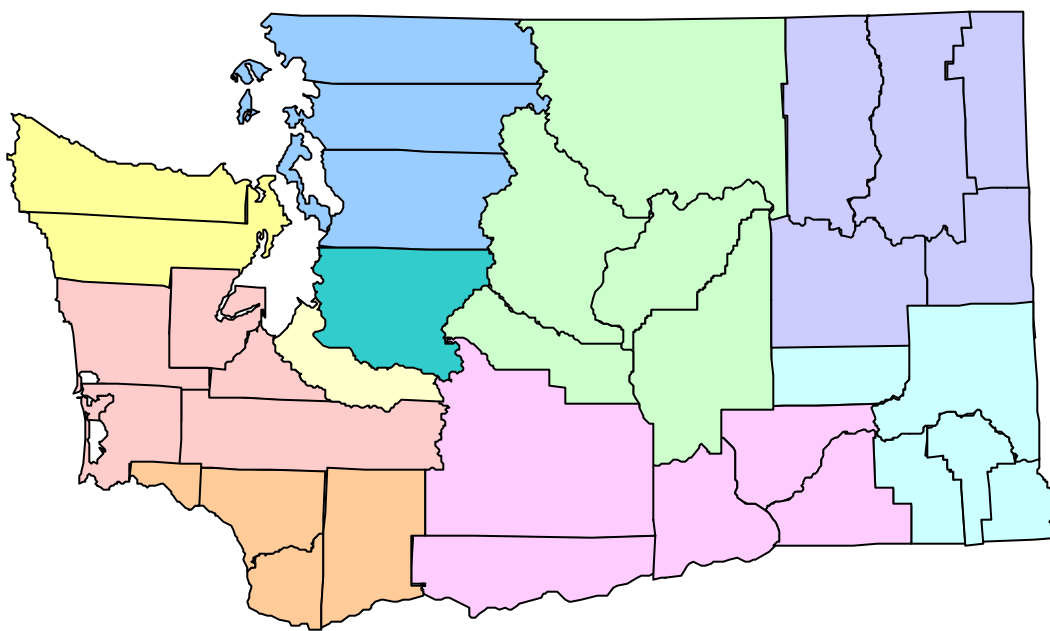**Washington State Department of Health**

Public Health Preparedness and Response for Bioterrorism

Proposal to the
Centers for Disease Control and Prevention
April 15, 2002

Washington State Department of
Health

Application to the
Centers for Disease Control and Prevention

In Response to Notice of
Cooperative Agreement #U90/CCU017010-03-1
93-003 CFD No. 0393003A02
Public Health Preparedness and Response for Bioterrorism

Washington State Department of Health
April 15, 2002

Washington State Department of
Health

Washington State Department of Health
Post Office Box 47890
Olympia, Washington 98504-7890

Table of Contents

I. Federal Forms:
- **Application 424**
- **Original Assurances**
- **Original Certifications**
- **Budget Forms**
- **Checklist**

IV. Focus Areas

V. Documentation of Local Involvement

VI. Letters of Endorsement

Executive Summary
Public Health Preparedness and Response for Bioterrorism
Work Plan

Purpose - The Washington State Department of Health (DOH) is submitting a work plan for approval to the Centers for Disease Control and Prevention (CDC) for funding to develop capacity and infrastructure for public health preparedness and response to bioterrorism. The primary focus of this stage of funding is assessment and planning. Capacity building is proposed where planning has already been accomplished. The ultimate purpose of the work is to build a statewide system with state and local public health jurisdictions prepared for and able to respond to acts of bioterrorism, other outbreaks of infectious disease, public health threats and emergencies.

Background - The challenge of preparing for and responding to a biological event is significant. Unlike the events of September 11, 2001 or other acts of overt violence, infectious disease outbreaks are often difficult to identify early on. There is no explosion or outward signs. Instead there is an ever-increasing number of individuals showing up at clinics, emergency rooms and health care providers offices. The illnesses may be scattered geographically and occur in a number of different jurisdictions at once, depending on source and mechanism of initial infection. Without methods to rapidly detect this manifestation throughout the health system, an effective response cannot be mounted in a timely and coordinated fashion. The introduction of bioterroism agents adds another layer of complexity, due to the lack of experience with these infectious agents, and because unlike naturally occurring outbreaks, these are initiated by people who intend to cause harm. As such, the methods and nature of exposure are unpredictable and outside normal disease transmission routes.

Approach – The proposed work plan will ensure system wide improvements through collaboration and coordination of state efforts with those of our key partners: local public health, hospitals, emergency management services, and health care providers. An effective system requires the rapid detection of illness by health care providers and labs, secure and dependable communication with public health disease investigators, and response plans to deliver necessary medicine or vaccines quickly. The system must provide clear health information to the public and technical assistance to the many different responders. Those responders all need appropriate and continuous training and education in the diseases of concern, and their individual roles in the overall system plan. Key partners in many areas, including local health, physicians, nurses, hospitals, emergency medical personnel, have been very involved in the work plan and are included in the proposed capacity development efforts.

The Work Plan - The work plan lays out the framework for a public health system that recognizes certain critical centralized capacities, such as the state public health lab and the development and maintenance of a statewide information technology system. It increases the local capacity to detect and investigate diseases and coordinate a local response. Regional plans that link hospitals, local health and emergency responders do not currently exist and this work plan will allow the development of such plans. Finally, the work plan will build capacity in DOH to respond to a public health emergency, and to test and exercise the resultant response plans.

The work plan is organized into six major focus areas with a number of CDC required critical capacities within each focus area:

- Area A: Preparedness Planning and Readiness Assessment
- Area B: Surveillance and Epidemiology Capacity
- Area C: Laboratory Capacity – Biological Agents
- Area E: Health Alert Network/Communications and Information Technology
- Area F: Communicating Health Risk and Health Information Dissemination
- Area G: Education and Training

Timeframe and Funding – The timeframe covered in this work plan is from May 15, 2002 to Aug 30, 2003. This effort is primarily a needs assessment and planning phase. It is anticipated that there will be additional funding in future years to address needs that cannot be met during this funding cycle.

Budget work sheets are provided following the narratives for each focus area. They summarize the distribution of funds within the focus area. The funding distribution among the various state, regional and local entities is provided in a table within focus area A.

Preparedness Planning and Readiness Assessment – this area deals with the assessment of the state's emergency preparedness and responsiveness to a bioterrorist event, major infectious disease outbreak, or other public health emergency. The state work plan proposes action to address each of the critical capacities:

<u>Leadership</u> – the agency will identify one key state public health official who will provide the strategic leadership for public health preparedness and planning. We will convene a state advisory committee to assist and advise the agency on the development and implementation of the work plan elements and ensure linkage of public health issues to other state efforts related to emergency preparedness and terrorism response plans. We will collaborate with the University of Washington in leadership development around the public health competencies associated with planning and preparedness.

An oversight steering group composed of key state, local, and hospital representatives will provide leadership and accountability. This group will meet regularly and monitor progress, accomplishments, barriers, and needs to alter approach.

<u>Assessment</u> – The agency proposes a coordinated assessment of hospitals, local health, and emergency management systems to determine existing capacities and identify gaps for subsequent planning efforts at the state and local level. We will use existing information to help conduct this assessment.

Included in the assessment work will be a review of the statutory and administrative codes under which public health actions would be taken in response to a biological emergency.

A regional system will help coordinate local health jurisdictions in assessment and implementation. This approach ensures that every local jurisdiction will create basic capacity, while strengthening response systems by virtue of a regional plan. The regional framework will include identification of a lead local health agency for each region, with that agency taking responsibility for providing assistance and guidance to the other agencies in the region. The needs of large metropolitan areas such as Seattle, as well as Washington cities and counties neighboring Portland, Oregon and Vancouver, B.C. have not been assessed in the context of a comprehensive state system and will need to be evaluated.

Preparedness and Response Planning - This critical capacity addresses the ability to exercise a comprehensive emergency management plan. The agency will meet this capacity by describing pre-event preparation, outlining the response to communicable disease emergencies, and highlighting the uniqueness of a biological event.

The agency will define roles involved in managing mass casualty and fatality events so that our comprehensive emergency plan is consistent with the state emergency management plan. A senior public health official will be designated as lead coordinator.

Each local health jurisdiction will produce a written plan around the public health functions they will perform during an emergency response. The local plans will be part of a coordinated regional plan and the state plan.

Federal Asset Coordination – This critical capacity addresses the agency's ability to coordinate with federal programs, most particularly the National Pharmaceutical Stockpile. We will develop plans for the receipt, storage, distribution and proper identification and training of individuals that will handle these pharmaceuticals during a time of emergency.

National Pharmaceutical Stockpile – This critical capacity is intended to establish the ability to manage the delivery and distribution of a large "push package." These "push packages," which are part of the stockpile, contain medical supplies and pharmaceuticals that would be delivered to the state within 12 hours of a request by the governor. Preparation includes local planning, training and exercises involving push package distribution plans.

Surveillance and Epidemiology Capacity – This section of the work plan deals with the detection and response to disease outbreaks and consists of three critical capacities:

Rapidly detect a terrorist event or disease outbreak through an efficient, mandatory reportable disease surveillance system – The work plan for this capacity is to increase available local and state disease surveillance staff. These people will work with key health care providers in identifying and reporting communicable diseases. DOH will develop and provide training on a secure, confidential system for local health agencies and health care providers. This will provide disease surveillance data through a Web-based system, known as Public Health Issues Management System (PHIMS). This will assure that local health jurisdictions can receive urgent disease reports from all parts of the state. We will pilot alternative disease surveillance strategies in selected regions, such as monitoring 911 calls or Emergency Room visits. A standard protocol will be developed and applied to regularly assess surveillance activities. Training will be

developed and provided to disease reporters and public health staff to increase awareness of the importance of surveillance systems.

Comprehensive and exercised epidemiological response plan – In order to meet this critical capacity, each region will designate an epidemiological response coordinator who will work with local health in their regions to develop local and regional response plans. These plans will use secure information systems, will be linked to the broader public health and hospital emergency response plans, and will be strengthened by mutual aid agreements, and training plans. This effort will focus on routine training and exercise of developed plans.

Rapidly and effectively investigate and respond to a disease outbreak – We will develop standardized protocols for public health investigation and response. Public health investigation and response will be routinely assessed to identify improvements. After-hours response plans will be developed by all local health agencies to provide a rapid response to urgent public health issues. Current communication modes will be expanded to ensure that urgent messages can be delivered and received in an effective and timely manner. Communication tools, education, and protocols will be developed and presented to public health and veterinary professionals to improve animal disease surveillance.

Laboratory Capacity – This focus area addresses the clinical laboratory capacity of the state to accurately and quickly identify a potentially infectious agent. It requires two critical capacities: 1) establishing rapid laboratory response capability with enhanced public health laboratory security and infrastructure and 2) assuring adequate capacity by developing a coordinated system of lab services in the state.

Rapid Service Response and Enhanced Infrastructure – This capacity will be met by increasing the number of trained microbiologists at the state Public Health Laboratories and investing in new technology. This will decrease the time it takes to identify potential pathogens using advanced DNA analysis.

Establishing a secure electronic communication system will assist in transfer of information and test results between laboratories, with our neighboring states, and with CDC. We will increase our emphasis on safe handling of biological agents and specimens.

We will establish plans with law enforcement agencies and hazardous material responders on sample collection, transport and chain of custody. Security at the state public health labs, including safe storage of equipment and samples or specimens sent to the lab, will be improved to ensure the safety of our staff and the public.

The surge capacity issue will be addressed by enhancing two local public health laboratories (Spokane Regional Health District and Public Health - Seattle and King County) so that they can perform critical tests as needed, and test environmental samples as appropriate. We will establish agreements with other advanced microbiology laboratories at the University of Washington, Washington State University, and Madigan Hospital so that they can provide confirmatory testing should the public health laboratory system become overwhelmed.

Assuring Adequate Laboratory Capacity – We will provide training and technical assistance to enhance the ability of private and public sector laboratories statewide to perform initial screening tests for microorganisms that may be associated with bioterrorism. We will establish an evaluation process, including proficiency testing and practice drills, to monitor the capability of laboratories around the state to correctly identify critical disease-causing microorganisms. The enhanced electronic communication system described previously will increase the ability of laboratories to share information. We will facilitate inter-lab agreements for mutual support and back up.

Health Alert Network - This focus area addresses the need to move information and data quickly and securely in order to detect or respond to a bioterrorism or other public health event. It is composed of four critical capacities.

Communications and Secure Connections – During a public health emergency, it's crucial that providers and state and local health agencies share information quickly and securely. This capacity is intended to provide a secure system to exchange medical information safely. We will work with local health to assure that 90 percent of the state's population lives in a health jurisdiction that is connected to this system. We will establish a secure Internet-based system for providing public health emergency information to public health officials, hospitals, laboratories, clinicians and local first responders. Authorized individuals will be listed in a directory that notes their level of access to the system.

Emergency Communications – This capacity ensures that a variety of communication systems are available during an emergency. We will assess current systems available to local responders; identify the best methods within regions (including redundancy); distribute needed equipment; establish necessary policies and agreements; and conduct systems tests. There will be a strong focus on working with existing emergency management systems and operation centers.

Protection of Data and Information Systems – This capacity focuses on the security of the information system. The work plan includes a review of state and local practices and policies on information technology security. That review will provide direction for consistency in systems and improving security. We will create a system of digital certificates to allow appropriate user access to a secure, Web-based information system, develop a secure machine-to-machine data transmission system. The system will be tested periodically to be sure it works.

Secure Electronic Exchange of Public Health Information – This capacity addresses the need to automatically transmit clinical data from laboratories and health care facilities to public health agencies and disease investigators. We will assess existing capacity, find gaps and needs, and provide equipment, software, training or policies to fill those gaps.

Once the capacity to exchange data is established, the data will be reviewed and analyzed by trained epidemiological investigators at the local and state level. On-going efforts include trend analysis (as data increases over time) and routine maintenance and quality control of the system.

Risk Communication and Health Information Dissemination – This focus area draws attention to the capacity of the public health system to provide critical public health information

during an emergency. It includes ongoing outreach to the general public and special populations on topics related to emergency preparation. Starting with an assessment of risk communication capacity on the local and system levels, the plan uses a mix of regional and system-wide resources to ensure public health system readiness.

Newly created system resources—both centrally and regionally located—will work with regional public health emergency communications advisory committees that may be established as part of regional workgroups created under the "Preparedness Planning and Readiness Assessment" of this project. The majority of their efforts will focus on providing a coordinated system-wide resource for risk communication training, building a comprehensive library of materials for system staff and the public, ensuring consistent public health messages, and supporting special community outreach efforts.

The work plan contains an interim plan to address risk communication needs should something occur before the existing capacity is improved. This interim plan calls for DOH to activate an *Emergency Communications Strategy* to provide support to the public health system through the DOH Communications Office. This emergency response plan includes activating an emergency call center, disseminating specific and general health information as necessary (to system partners and public) based on the nature of the emergency, and responding to inquiries from the media and general public.

Education and Training – This focus area deals with a delivery system for education and training of public health officials, emergency responders, and health care providers. The plan proposes multiple learning strategies for training public health officials. Generally, these can be achieved with three factors:
- Human Resources – state and local training coordinators throughout the regions.
- Technology – build on existing community assets and enhance technology to offer other training options, including video conferencing and Web-based learning.
- Barriers – identify and remove or reduce access barriers to learning opportunities, including subsidies to assist with travel and time away from work during training.

Integration with Hospital Planning – This work plan for the CDC bioterrorism preparedness funding application is coordinated with the proposal to Health Resources and Services Administration for hospital planning. The Health Resources and Services Administration funding application is intended to upgrade the preparedness of hospitals in Washington, and their partners, to respond to bioterrorism. The primary focus of is assessment and planning. Ultimately, Washington will build a hospital system capable of responding to acts of bioterrorism, other outbreaks of infectious disease, public health threats and emergencies. It is important to coordinate these two applications, and examples of this coordination include:

Needs Assessment – careful attention is made to coordinate the needs assessments required in both proposals. The existing emergency medical services regional councils will assist with linking hospital needs with those of first responders and including this information into local and regional preparedness planning related to developing their emergency response plans.

Regional Preparedness Plans – the hospital plans to develop regional preparedness plans will include elements related to antibiotic and vaccine distribution and workforce development. The activities in the CDC work plan for National Pharmaceutical Stockpile planning, communication systems and training/education efforts clearly link to these proposed activities. It is proposed that exercises and drills be coordinated to test hospital and public health plans jointly.

Establish Critical Benchmarks – The HRSA proposal contains several benchmarks that lead to coordination. In particular is the creation of the Hospital Bioterrorism Planning Committee, which will be linked to the larger DOH Bioterrorism Response Advisory Committee. A smaller project-focused Bioterrorism Response Steering Committee is planned under the leadership section of Focus Area A, and a hospital representative will be a member of that committee.

Infrastructure – This element of the Health Resources and Services Administration proposal deals with the long-term maintenance of hospital plans within the state. The integration of the Health Resources and Services Administration plans with CDC and Metropolitan Medical Response System plans is noted. There is opportunity for coordination in the review of legal authorities and regulatory support structure around isolation procedures.

Data Collection – One critical capacity in the CDC proposal is the development of a secure information system through which we can send and receive clinical data and important public health information. That information system will serve to assist hospitals with the transfer of critical data (bed counts and availability) as well as provide reports on the progress made in filling the gaps identified in the needs assessments.

Integration with Metropolitan Medical Response System - Three cities in Washington (Seattle, Tacoma and Spokane) are designated planning areas under the Metropolitan Medical Response System plan guidance. The plan for Seattle is completed. Tacoma and Spokane are in the process of developing plans. When these plans are available, they will be reviewed along with the Portland, Oregon plan. They will be integrated into the statewide planning efforts.

The unique needs of large metropolitan areas are not clearly identified. While the assets of these cities are considerable, so are the perceived intricacies and risk. The needs of the major metropolitan core (Seattle/Tacoma/Everett) along with Portland, Oregon to the south and Vancouver, B.C. to the north will need to be evaluated and integrated into the local, regional and state plans following the assessment activities.

Integration with Tribes and Federal Facilities – There are 29 Federally recognized Tribes in Washington. However, few have significant health care facilities that might serve as an asset during a biological event or infectious disease outbreak. Communications have been initiated with Tribal health care organizations to seek representation on the Bioterrorism Response Advisory Committee, but the primary communication with Tribal communities is the need to be engaged at the local and regional planning level, through integration in the local emergency response plans.

There are several major federal facilities in Washington, including VA Hospital and several military health care facilities. We will have representatives from these facilities on the state advisory committee.

Conclusion – This federal funding application process is the beginning of a long-term responsibility that will continue to evolve. Much of the work in the application is built on the foundation DOH established in more than two years of previous bioterrorism response planning. Our broad, system-based approach to the previous work on bioterrorism and public health emergency response has been extended to this application. People from throughout DOH have been joined by local health, hospitals, providers and emergency management, who have all played a key role in this work. We have charted a challenging course by inviting everyone to the table. The benefits include having the entire public health system involved from the start, so we can work together to be better prepared today than we were yesterday, and better prepared tomorrow than we are today.
.

Public Health Preparedness and Response for Bioterrorism

BENCHMARKS

Benchmark #	Activity	Completed √
1	Designate an executive director.	√
2	Establish an advisory committee	√
3	Establish timeline for assessment of emergency preparedness and response capacities.	√
4	Establish timeline for assessment of statutes, regulations and ordinances	√
5	Establish timeline for development of statewide plan for responding to incidents of bioterrorism, infectious disease outbreaks and other public health threats and emergencies.	√
6	Establish timeline for development of regional plans (for #5)	√
7	Develop an interim plan to receive and manage items from the National Pharmaceutical Stockpile.	√
8	Establish a timeline for developing a system to receive and evaluate urgent disease reports from state and Local Health Jurisdictions on a 24/7 basis.	√
9	Assess epidemiologic capacity and establish a timeline for achieving the goal of providing at least on epidemiologist for each MSA with a pop. > 50,000.	√
10	Establish a timeline for development of plan to improve working relationships and communication between level A labs and level B/C lab response networks labs.	√
11	Establish a timeline for a plan that ensures that 90 % of population is covered by the Health Alert Network.	√
12	Establish a timeline for development of a communications system that provides a 24/7 flow of critical health information among hospital emergency departments, state and local health officials and law enforcement officials.	√
13	Develop an interim plan for risk communication and information dissemination to educate public re: risks and public response.	√
14	Establish a timeline to assess training needs for emergency personnel, infectious disease specialists, public health staff and other providers.	√

Benchmark 1

Mary C. Selecky will serve as the executive director of the Bioterrorism Preparedness and Response Program. <u>APPOINTED March 2002</u>

Executive director duties:
- Chair the Bioterrorism Response Advisory Committee.
- Clarify the goal and purpose of the Bioterrorism Preparedness and Response Program (the Program).
- Take responsibility for overall Program direction and oversight
- Select Program participants (stakeholder involvement and staffing) through a transparent process.
- Provide ongoing guidance to all Program stakeholders and staff.
- Ensure effective organizational planning.
- Manage resources effectively.
- Ensure Program evaluation and monitoring of the proposed programs and services.
- Provide support for the Program's public image and communication links to stakeholders.

Executive Director Curriculum Vitae

Mary C. Selecky
Department of Health
1112 S.E. Quince Street
Olympia, WA 98504-7890
mary.selecky@doh.wa.gov
360-236-4030   Fax 360-586-7424

<u>Secretary of Health – March 15, 1999 to Present</u>
Washington State Department of Health, Olympia, Washington

<u>Acting Secretary of Health – October 5, 1998 to March 15, 1999</u>
Duties: Provide leadership for the Washington State Department of Health in fulfilling its
responsibilities of protecting and promoting public health. Manage a cabinet-level agency of
1,200 staff with a biennial budget of $500,000,000.

<u>Administrator – January 1, 1979 to March 15, 1999</u>
Northeast Tri-County Health District, Colville, Washington
Duties: Provide administrative duties and leadership for a three-county public health district
serving Ferry, Pend Oreille and Stevens Counties with 45 staff and a $2.2 million budget.

<u>Previous Work Experience</u>
Interim Director – December 1, 1986 to August 1, 1988
Stevens County Counseling Services, Colville, Washington
Duties: Provide interim management leadership for county agency which provided mental
health, drug, alcohol and contracted developmental disability services.

<u>Administrative Assistant/Administrator – February 1975 – December 31, 1978</u>
Trico Economic Development District, Colville, Washington
Duties: Supervised staff and projects for a three-county economic development district
according to the annual Overall Economic Development Plan.

<u>Assistant Dean of Students – September 1971 – April 1974</u>
University of Pennsylvania, Philadelphia, Pennsylvania
Duties: Supervised all student activity organizations and new student orientation, prospective
student recruitment and interviewing.

<u>Assistant Director of Student Life & Environment – September 1971 – April 1974</u>
Sarah Lawrence College, Bronxville, New York
Duties: Supervised and responsible for all housing assignments, student counseling and
activities; interviewed and recruited prospective students; coordinated community events at the
college.

<u>Education:</u>   1969, BA, History & Political Science, University of Pennsylvania

Honors:

1987   Washington State Public Health Association Annual Award, Association for
            Sexuality and Training Merit Award
1993-1999   National Association of County Health Officials (NACCHO) Award of
            Appreciation
1995-1996   Washington State Rural Health Association – Outstanding Contribution to Rural
            Health Award
1993-94   National Public Health Leadership Institute Scholar

Selected Organizations and Affiliations (Current):
Association of State and Territorial Health Officers (ASTHO) (president-elect)
Washington Rural Health Association
Public Health Leadership Society
Washington State Public Health Association
American Public Health Association
American Association of University Women
Rotary International
Northeast Washington Rural Resources Board of Directors (member emeritus)
Washington Governmental Entity Pool (member emeritus)

Past Organizations and Affiliations:
Co-chair Governor Gary Locke's Transition Team Health Roundtable
Co-chair Governor Mike Lowry's Roundtable on Federal Reductions
Public Health Improvement Plan Steering Committee
American Indian Health Care Delivery Plan Advisory Committee
Stakeholders Committee of Washington Health Services Commission
Technical Advisory Committee Member for Basic Health Plan Commission and
Washington Health Care Commission
Washington Rural Health Commission
Past Chairman, DSHS Medical Assistance Advisory Committee
National Association of City and County Health Officials (former board member)
Washington State Association of Local Public Health Officials (former chair & board member)
N.E.W. Health Programs Board of Directors

Academic Presentations:
Clinical Associate Professor, School of Public Health, University of Washington, Gonzaga
University School of Nursing, topic: Leadership
Western Washington University, topic: Leadership
Public Health Leadership Institute, topic: Political Leadership
Southeast States Public Health, topics: Leadership, Public Health Systems Improvement and
Core Functions
Illinois Public Health Leadership Institute, topic: Rural Health

Benchmark 2a

a) Charter of the Bioterrorism Response Advisory Committee DRAFT ADOPTED 3/5/2002

Working Charter Bioterrorism Response Advisory Committee

Background: The Bioterrorism Response Advisory Committee consists of partners and representatives of stakeholder groups that are committed to creating a plan to prepare for and respond to public health threats and emergencies (as per section ESF-8 of the state emergency plan). This includes a response to bioterrorism and outbreaks of infectious diseases through comprehensive planning, training and evaluation. The U.S. Department of Health and Human Services (CDC and HRSA) is funding this planning effort through cooperative agreements with the Washington State Department of Health (DOH) beginning in February 2002.

Proposed membership: *(see the following roster)*

Roles and Responsibilities: The Advisory Committee has an advisory relationship found in the State of Washington's formal plan, "The Bioterrorism Preparedness and Response Program." It is responsible to:

1. Carry forward the goal of the state's emergency planning to address and enhance ESF-8, particularly our preparedness and response to infectious disease.

2. Proactively serve as an information conduit to communicate and educate members' respective stakeholders on state plan development, expectations and needs.

3. Advise the agency on progress toward state plan implementation. This will include identifying gaps and trouble spots, lessons learned, significant innovations, successes, and opportunities, as well as providing possible solutions to problems and barriers to implement a state plan.

4. Advise the agency on coordination of Advisory Committee efforts with other state efforts, including the work of the Governor's Committee on Terrorism, to address public health emergencies related to bioterrorism, infectious disease outbreaks, and natural or man-made disasters.

Meeting Process: It is anticipated that the Advisory Committee Chair will convene the Advisory Committee no more than <u>twice annually</u>. Meetings will be held in either Olympia or the Puget Sound area. Travel expenses for members will be reimbursed upon request. The Washington State Department of Health (DOH) will provide meeting staffing support. The majority of Advisory Committee communication and work will be conducted via electronic mail (e-mail).

Benchmark #2b

b) Roster of the Bioterrorism Preparedness and Response Program Advisory Committee.
<u>**COMMITTEE MEMBERS APPOINTED AND IN PLACE AS OF APRIL 5, 2002.**</u>

State Department of Health
Mary Selecky, CHAIR
Secretary, Washington State Department of
    Health

Local Health Departments
M. Ward Hinds, MD
Chair, Washington State Association of Local
    Public Health Officials (WSALPHO)
Health Officer, Snohomish Health District

Alonzo Plough, PhD
Director and Health Officer, Seattle King County
    Pubic Health District

**Washington State Emergency Management
    Association**
Ed Reed
Program Manager,
Pierce County Department of Emergency
    Management

Emergency Medical Services
Brian Hurley
Chair, EMS Committee
Washington State Council of Firefighters

Office of Rural Health
Laurie Wylie
Executive Director, Western Washington Area
    Health Education Center (AHEC)

Area Health Education Center (AHEC)
Steven Meltzer
Director,n at Washington State University

Fire Department
Gary Aleshire, Chief
Medical Services, Lakewood Fire Department
Washington State Fire Chiefs Association

**Washington Association of Coroners &
    Medical Examiners**
Dan Blasdel
President, WACME
Franklin County Coroner

Emergency Rescue Workers
Mike Turay
Mason County Medic One

Washington Ambulance Association (WAA)
Occupational Health Workers
Lee Glass, M.D.
Washington State Department of Labor and
    Industries

Washington State Department of Agriculture
Diane Dolstad, Program Manager
Animal Health, Food and Diary Laboratory

University (medical)
Walter E. Stamm, M.D.
Professor of Medicine, Department of Medicine
University of Washington

University (public health)
Mark Oberle, M.D.
Associate Dean for Public Health Practice
Professor of Health Service and Epidemiology
School of Public Health and Community
    Medicine
University of Washington

University (veterinary school)
Terry F. McElwain, D.V.M., Ph.D.
Professor and Executive Director, Washington
    Animal Disease Diagnostic Laboratory
Director, Animal Health Research Center,
    College of Veterinary Medicine,
Washington State Univ.

Community Colleges
Jim Crabbe
Senior Administrator, Workforce Education
State Board for Community and Technical
    Colleges

**Washington Association of Community and
    Migrant Health Centers**
Gloria Rodriquez, CEO
Washington Association of Community and
    Migrant Health Centers

Red Cross
Bev Ritter
American Red Cross of Snohomish County

Hospitals – Veterans Affairs
Les Burger, M.D.
Acting Director,
Veteran's Integrated Service Network (AK, OR,
    WA, ID)

Hospitals – Military
Brig. General Ken Farmer
Madigan Hospital

Hospitals – Public/Private
Gordon McLean, Hospital Administrator
Mount Carmel Hospital

Mount Carmel Hospital
Gordon McLean, CEO

Northwest Hospital
Peter Rigby,
Director of Therapies

Washington State Nurses Association
Louise Kaplan, PhD
President, WSNA

Washington State Medical Association
Nancy Auer

Tribal
Joe Finkbonner
WSMA, Past President
Director, Northwest Tribal Epidemiology Center
NW Portland Area Indian Health Board

**Washington State Clinical Laboratory
    Advisory Council**
Stephen Sarewitz, M.D.
Valley Medical Center

**Washington State Pharmacy Association
    (WSPA)**
Rod D. Schaffer
CEO, WSPA

Washington State Psychological Association
Lucy Homans, Ed.D.

Legal
Kathleen D. Mix
Chief Deputy Attorney General

Law Enforcement
Bill Hanson
Executive Director, Washington Council of
    Police & Sheriffs

Alternate:
Washington State Hospital Association
Brenda Suiter,
Director, Rural and Public Health Policy

Benchmark 3

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
Area A, Section I, Benchmark #3	Develop State-wide and Regional plans to respond to bioterrorism and other emergencies	Conduct an integrated assessment of the public health system capacities related to bioterrorism, infectious disease outbreak and other public health threats Review existing county emergency plans for inclusion of PH/ ESF-8	LHJs, hospitals[*], emergency management agencies and first responders (fire, law)	Project leader and support staff are identified Key stakeholders committee for needs assessment development is established	April 30, 2002
	Develop Assessment Tool	Convene assessment development committee Determine assessment scope and boundaries, requirements and fundamental approach (Self audit, team approach or a combination of both) Work with IT staff to design mode of administration and needed security measures Coordinate with HRSA group[*] to identify redundancies or additional questions needed Develop form		Assessment tool is developed	April 30, 2002
	Test Assessment tool	Peer review Field test		Testing of tool is complete	May 31, 2002
	Train Assessment team	Select, develop program and train assessment implementation team		Team is assembled and trained	June 30, 2002
	Implement needs assessment tool	Regional staff conduct assessments in each county		Assessments completed	July 31, 2002

---

[*] CDC – HRSA Coordination

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
3	Analyze data results	Review results and engage in any further discussion as necessary Identify gaps or needs Make recommendations Consider budgetary implications Prioritize needs Implement capacity building program			August 15, 2002
	Publish and disseminate assessment results	Data is compiled in useful formats Report is drafted Legal review for protection from public release	Attorney General	Report is published and disseminated	September 1, 2002

Benchmark 4

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
4	Assess and improve existing state statutes and regulations	Identify state statutes and regulations which could be strengthened and clarified, including those relating to (1) credentialing and licensure, (2) authority for executing emergency health measures, and (3) addressing liability of health care personnel Clarify the emergency authorities of local health officers, including quarantine and isolation, establish due process protections in rule, and enhance enforcement of emergency actions.	AGO, EMD, SBOH, WSALPHO, LHJs, Law enforcement, Legal Counsel for LHJs , Judiciary (e.g., Judges Association/ Administrator for the Courts), Civil Liberties Groups (e.g. ACLU/Columbia Legal Services)	Establish a representative group to review existing assessments, conduct gap analysis, and identify emergency authorities to be strengthened and clarified Prepare a report on the assessment of existing state statues and regulations, draft a plan for the enforcement of emergency orders and the process of protecting civil liberties, and distribute to state and local agencies and elected officials responsible for oversight and improvement of health agencies' legal authorities Revise rules pertaining to emergency powers and duties of local health officers	5/02 9/02 (for any recom-mended statutory changes) & 12/02 (for recommen ded rules) 1/03
4	Assess local government legal authorities	Identify any local ordinances or county codes relating to emergency health powers	WSALPHO/LHJs, Legal Counsel for LHJs	Survey and gather local health ordinances and county codes relating to emergency health powers Establish a representative group to review and assess the ordinances and county codes Prepare a report for use by local governments to improve emergency health powers ordinances and codes	5/02 5/02 2/03

Benchmarks 5 & 6

Work Plan Timeline

Benchmark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
Area A, Section II, Benchmarks 5 & 6	Develop local, state-wide and regional plans to respond to bioterrorism and other emergencies	Recruit and hire (or identify) planners/ emergency coordinators	LHJs	Planning staff is hired or planning responsibility assigned to existing staff	5/02
		Develop guidance for plan completion Train planners and local emergency preparedness coordinators on plan development and assessment findings	LHJs, hospitals,[*] EMD	Planning guidance and training complete;	7/02
		Begin development or revision/updating of local health jurisdiction and hospital plans using data from capacity and needs assessments	LHJs, hospitals,[*] EMAs	Regional and field staff confirm progress	8/02
		Local plan development continues with technical assistance from state and regional planners Begin development of regional response plans	LHJs, hospitals,[*] EMAs	Regional and field staff confirm progress	9/02
		Update ESF-8 to state CEMP	State agencies, EMD	Updated ESF-8 Annex submitted to EMD	10/02

---

[*] CDC – HRSA Coordination

Benchmark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		Complete initial drafts of LHJ and hospital plans Begin development of state-wide bioterrorism response plan	LHJs, hospitals,[*] EMAs, State agencies, EMD	Regional and field staff confirm progress	12/02
		Conduct Tabletop Exercises of local Response Plans	Local public safety agencies,[*] hospitals,[*] and other community partners	Exercises completed	3/03
		Revise local plans based on lessons learned from tabletop exercises	Local public safety agencies,[*] hospitals,[*] and other community partners	Plans updated, regional and field staff confirm progress	4/03
		Participate in TopOff Full-scale Exercise (tentative)	Federal, state, regional, local, players, including hospitals[*]	Exercise completed, lessons identified	5/03
		Complete initial drafts of Regional Response Plans, incorporating provisions of capacity assessments, local plans, and lessons learned from tabletop exercises	LHJs, other local, state, and federal agencies; hospitals[*]	Initial drafts completed	6/03
		Complete final drafts of Regional plans Complete initial draft of Statewide Response Plan	LHJs, other local, state, and federal agencies; hospitals[*]	Regional plans finalized; statewide plan drafted	8/03

---

[*] CDC – HRSA Coordination

Benchmark #7

The state of Washington has more than an interim plan in place. A draft of the comprehensive NPS plan is close to completion. Per verbal guidance received in the March 21, 2003 conference call, the plan itself (over 100 pages) is not included in this work plan The plan covers decision-making, receipt, repackaging, distribution, dispensing, return, training and exercising. The plan is divided into sections (tabs), which are individual stand-alone guidelines for a particular function of the Washington NPS plan. The draft tabs are in various stages of development and are organized as follows:

- **Tab A Roles and Responsibilities:** This tab assigns specific roles and responsibilities to federal and state agencies.
- **Tab B Decision Making Process:** This section provides guidelines used in determining if and when the Governor or one of the designees should request deployment of the NPS.
- **Tab C Preparing to Receive**: This section provides specific duties to members of the DOH, LHJ, L&I, CDC, as well as the local airport authorities and local police departments. (This tab outlines the specifics regarding facilities, personnel, and equipment required to receive the NPS push packages).
- **Tab D Managing**: This portion is under the direct control of DOH. However, it is at this step in the process that the LHJs become fully involved. The LHJ is to be responsible for assisting the state as needed with staff to expedite the repackaging and distribution of bulk supplies for delivery to LHJ dispensing sites.
- **Tab E Dispensing**: The lead for the Dispensing portion would be the LHJ in the affected area. The guidelines within the plan are intended to assist the LHJ setup a dispensing clinic and dispense the medications needed by potentially exposed persons, again with DOH assistance as requested by the LHJ. In order to dispense medications, a large number of qualified pharmacists and pharmacy assistants would are utilized, as well as other medical professionals and volunteers.

The most critical portion of this plan (dispensing tab) was tested in a January exercise at the University of Washington. CDC (Adcock) observed this drill and debriefed the state planning committee. Lessons learned from the event will be reflected in the next version of the plan. CDC NPS program has informed the state that this plan was the first state plan to be evaluated using the CDC plan evaluation instrument. While indicating that Washington's plan is satisfactory, CDC NPS program staff did provide some recommendations which have been incorporated in plan updates. The plan now contains a section addressing training and exercises, including identification of staff to be trained.

Under the state's NPS plan, the state Department of Health will receive the stockpile, repackage as necessary, and distribute its elements to the local health jurisdiction(s) and hospitals affected by the emergency event. These activities will be coordinated and monitored from the state EOC. State and local agencies (e.g., law enforcement and transportation) will assist as required. The state NPS plans contains a dispensing "template" that LHJs can use on an interim basis. Local health jurisdictions will receive funding through this grant to fully develop plans to dispense NPS elements to affected persons. This template was developed by Public Health Seattle-King County with considerable input from the state NPS planning committee.

Benchmark 7

Benchmark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
7	Interim NPS Plan	Finalize state NPS Plan Begin Development of LHJ NPS plans	LHJs, Pharmacies, EMD	Draft plan is completed, personnel are identified to be trained	7/02
7	Interim NPS Plan	Begin Development of Regional NPS support plans	LHJs, Pharmacies, EMD		
	Participate in exercises conducted by federal agencies	TOPOFF II	DOJ, FEMA, EMD, local jurisdictions	Health agencies participate in TopOff 2 as scenario warrants, gathering lessons learned	5/03
7	Interim NPS Plan	Complete draft NPS plan at local and regional levels	LHJs, Pharmacies, EMD	Draft plan is completed, personnel are identified to be trained	8/03

Benchmark 8

Prepare a timeline for developing a system to receive and evaluate urgent disease reports from all parts of your state and local public health jurisdictions on a 24-hour per day, 7-day per week basis.

As described in Focus Area B, Critical Capacity A, the Washington Administrative Code requires reporting of disease by health care providers, laboratories, and other agencies, with immediate notification for outbreaks or conditions of major public health significance, including diseases potentially associated with bioterrorism. Washington State Department of Health Communicable Disease Epidemiology maintains 24 hour on call coverage by a medical epidemiologist to receive reports directly from disease reporters if a LHJ cannot be reached after regular working hours.

In order to improve our ability to receive and evaluate reports of conditions having urgent public health implications, Washington State has designed and is developing PHIMS (Public Health Issue Management System), a secure, electronic disease surveillance system that will allow LHJs to investigate and electronically report cases of notifiable conditions to the state. In conjunction with the development of PHIMS, the Disease Condition Database (DCD), a state repository for notifiable conditions data, is also being developed. When a case captured in PHIMS meets reporting requirements (WAC 246-101), the required data will be automatically updated in DCD. DCD will also be the state repository for notifiable conditions not reported through PHIMS (e.g. birth defects, pesticide poisoning, blood-lead levels).

PHIMS Version 1.0 will allow LHJs to capture data from case investigations including: demographics, reporting source, risk factors and exposures, contacts, and clinical information, including laboratory results and treatment. The system can then be used to report cases to DOH electronically, 24 hours a day, 7 days a week. PHIMS has been designed in partnership with the local health agencies of Washington State, from inception through all phases of system development. PHIMS architecture and design standards have been developed according to NEDSS standards and in compliance with the NEDSS Base system and the Public Health Conceptual Data Model.

PHIMS Version 2.0 will add conditions not included in Version 1.0 (e.g., tuberculosis and vaccine adverse events reporting), will allow linking of data for the investigation of food- and waterborne outbreaks, and will modify the PHIMS application and database to be patient-based, rather than disease- or condition-based. This final modification will allow better analysis of longitudinal data related to certain notifiable conditions such as sexually transmitted diseases. Version 2.0 will also include a web entry screen for use by health care providers to allow reporting directly via PHIMS. This version will include integration with the laboratory reporting systems as proposed in Focus Area E,[*] as well as integration with the alert and notification features of the Health Alert Network (HAN).

DCD Version 1.0 will be implemented in conjunction with PHIMS Version 1.0. It will include an automated reporting interface from PHIMS (PHIMS-DCD Integration Implementation) and a

---

[*] Focus Area Integration

quality assurance interface to ensure state and national case definition criteria are met for each reported case. As the state repository for notifiable conditions data, DCD will be a source for epidemiological assessment. Included in the implementation of DCD will be conversion of data from existing systems and development of a standard CDC interface for reporting nationally notifiable conditions.

Ultimately, it is envisioned that PHIMS-HAN Integration will utilize information recorded in PHIMS to automatically alert designated persons at LHJs and DOH whenever a case or outbreak of interest (i.e. critical agent) is reported. Once data regarding the situation is confirmed, the public health emergency response system would then be alerted via e-mail, broadcast faxes, pagers, and automatically dialed voice mail messages (see description of WA-SECURES, Focus Area E, Critical Capacity A.[*])

---

[*] Focus Area Integration

Benchmark #8

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
BCCA/#8	Web-Based Data Entry and BT and Communicable Disease Investigation Application	Finish Construction of PHIMS 1.0	Pilot LHJs, PHIMS and DCD Contractors	Completion of initial development and implementation in three pilot LHJs	7-02
BCCA/#8	Web-Based Data Entry and BT and Communicable Disease Investigation Application	Implementation of PHIMS 1.0 across Washington's LHJs	LHJs	Deployment in 90% of LHJs	12-02
BCCA/#8	State Level Integrated Data Repository	Establishment of Technical Environment for DCD 1.0, Migration of Legacy Data Sets, Implement QA Interface	DOH	Deployment in Production Environment	12-02
BCCA/#8	Improve Web-Based Data Entry System and Integrated Data Repository to meet NLDM Extension of HL7 RIM	Design and Construction of PHIMS 2.0 and DCD 2.0	LHJs, HCPs	Deployment to DOH and all LHJs Deployment to selected infectious disease practitioners	8-03

Benchmark 9

Assess current epidemiologic capacity and prepare a time line for achieving the goal of providing at least one epidemiologist for each Metropolitan Statistical Area (MSA) with a population greater than 500,000

Provide a brief description of how current epidemiological capacity compares to the goal.

In Washington State there are 34 local health jurisdictions (LHJs) that represent 39 counties. Washington State has three Metropolitan Statistical Areas (MSAs) with a population greater than 500,000: Seattle, Tacoma (Pierce County) and Snohomish County. The LHJs representing these MSAs each have at least one epidemiologist; however, this minimum goal does not provide the capacity that is needed in these LHJs or in other LHJs across the state to adequately address communicable disease surveillance.

The state's 2000 Public Health Emergency Preparedness Assessment (PHEPA) identified only 11 LHJs employing at least one full-time epidemiologist. In many cases this epidemiologist's scope of work did not include communicable disease. Additionally, in many LHJs, staff work in multiple program areas and disease surveillance is a very small part of what they do. Thus, most LHJ staff do not have time available for developing relationships with health care providers to increase reporting, or for developing standard protocols for disease reporting. PHEPA also identified a lack of daily monitoring by LHJs of key health indicators such as emergency department utilization, 911 calls or ambulance runs, which are potential additional sources of data to detect outbreaks.

Provide a timeline that addresses how and when the recipient will achieve the goal.

Washington's public health system proposes to address critical epidemiology and surveillance capacities utilizing a state, local, and regional approach. Ten public health regions were created to provide opportunities for local collaboration toward the critical capacities in the LHJs in their respective region. The population in these regions ranges from 85,700 to 1.7 million. A lead LHJ will coordinate regional activities; Spokane County will be the lead LHJ in two regions.

Population in Region	Number of Regions
Less than 250,000	2
250,000 to 500,000	5
500,000 to 750,000	1
750,000 to 1,000,000	1
More than 1,000,000	1

A more specific assessment of regional epidemiologic capacity is needed. Under the guidance of DOH and in conjunction with Focus Area A,[*] an initial assessment of epidemiology capacity will be conducted in all ten regions by September 2002. Following the regional needs identified in

---

[*] Focus Area Integration

this assessment the lead LHJ will provide a regional plan for addressing the needs in order to meet the critical capacities.

Funds will be provided for enhancing local and regional communicable disease staff capacity. One model to add epidemiologic capacity may designate a regional Epidemiology Coordinator to assist each LHJ in their region in assessing and developing critical capacity for early detection as evidenced by a timely and complete surveillance system (see Focus Area B, Section I). Public health regions may also designate Epidemiology Response Coordinators who will work with the other regional coordinators and the state response coordinator to develop criteria for standardized protocols and epidemiologic surge capacity that will provide the basis for a statewide Epidemiologic Response Plan (see Focus Area B, Section II). The regional coordinators will provide epidemiology support through mutual aid agreements to LHJs in their region when assistance is requested. DOH will have two lead coordinators (one for epidemiology and one for response) who will work with the regional coordinators to provide guidance, training and to develop best practices in order to ensure progress is being made toward the critical capacity in each region.

The regions may also choose to include Communicable Disease Liaisons, a position developed in Spokane Regional Health District (SRHD) to increase communicable disease reporting. These liaisons work with other public health communicable disease staff and notifiable condition reporters to build relationships which facilitate timely treatment, referral, and reporting of persons with notifiable conditions. These staff could also provide information about public health services and programs and disseminate updates about communicable disease treatment and control. They would work in the field to link providers and their staff with the experts at the LHJ, and perform other tasks necessary to meet the critical capacities.

Benchmark 9

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
#9	Improve effectiveness of public health response	Convene regional working groups to discuss optimal staffing models	LHJ	Regional workgroups provide staffing models to achieve critical capacities	05/15/02
#9	Improve effectiveness of public health response	Develop position descriptions for state coordinators; recruit and hire Epidemiology and Response Coordinators at the state level	LHJ	DOH Coordinators Position Descriptions Developed State Coordinators hired	04/15/02 05/30/02
#9	Improve effectiveness of public health response	Conduct an initial assessment of current epidemiologic capacity in conjunction with focus area A[*]		Assessment tool created Pilot tested Administered Analyzed	5/01/02 6/01/02 7/30/02 8/15/02
#9	Improve effectiveness of public health response	Develop position descriptions for regional Response Coordinators	LHJ	Regional Coordinator Position Descriptions developed	5/30/02
#9	Improve effectiveness of public health response	Based on gaps identified in assessments, LHJs will recruit and hire Epidemiology and Response Coordinators at regional levels Recruit and hire Epidemiology and Response Coordinator in identified jurisdictions within region.		Coordinators hired	08/30/02
#9	Improve effectiveness of public health response	Conduct meeting with all regional Epidemiology and Response Coordinators; Work with regions having staff recruitment difficulties to provide training or other resources		Regional meetings conducted	09/01/02

---

[*] Focus Area Integration

Benchmark #: 10

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
10	Laboratory Program Advisor	Recruit and hire	WA DOH Personnel; Other SPHL; State partners; NLTN	• Recruitment announcement • Offer of employment	08/02
	Laboratory Information (LITS+) Specialist	Recruit and hire	WA DOH Personnel; Other SPHL; State partners	• Recruitment announcement • Offer of employment	08/02
	Laboratory-based assessment workgroups	Inter-laboratory proficiency testing programs	Level A & B labs; CDC; State Training Coordinator	• Identify participants • PT plan in place • Communicate with LRN Labs for PT testing	11/02 11/02 01/03
		Improvement of networks for electronic communications	WAPHL; Level A & B Labs; WA PHL IT	• Draft of network plan • Documentation of partners coming on-line	12/02
	Survey of additional Level A laboratories	Survey laboratories	Level A Labs	• Final draft of survey • Survey result summary	08/02 10/02
	Establish Lines of Communication with Level A & B Labs	Site visits	Level A & B Labs; CDC; Other SPHL; Other WA State Programs	• Travel documentation	09/02
		Regional meetings	LHJ; NLTN; CDC; State Train Coord; Level A/ B Labs	• Travel documentation	10/02
		Broadcast faxes	LHJ; Other SPHL; Level A/B Labs; DOH Program	• Fax documentation	08/02
		Newsletter	LHJ's; State Train Coord; Level A/B Labs	• Copy of newsletter articles	06/02
		Internet sites	LHJ; Level A/B Labs; WA PHL IT staff	• Documentation of website address	08/03
	Level A laboratory training	Rule out testing	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Laboratory safety practices	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Safe specimen packaging	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		Appropriate referral	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
	Provide guidance to Level A & B Labs	Safety practices	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Quality control and assurance practices	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Adequacy of staffing	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Internal Training within Level A laboratories	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
	Develop Agreements with higher level labs for assessment of molecular capabilities	Perform molecular subtyping, BSL 3 testing & molecular methods for direct detection	Level B Labs; CDC; LHJ	• Level B Cooperative agreements • Proficiency testing documentation	08/02
	Electronic communications network	Collaboration with Focus Area E & Planning	IT services; LHJ; Level A/B Labs; CDC	• Planning documentation	08/03
	Interstate and International working relationships	Contacts with counterparts in international communities	International public health agencies; CDC; Other SPHL	• Planning documentation	06/02

Benchmark 11

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
A-1	Implement HAN Architecture	Snohomish County	SHD, SCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-02
A-1	Implement HAN Architecture	Whatcom	WCHHS, WCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-02
A-1	Implement HAN Architecture	Yakima County	SHD, SHCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-02
A-1	Implement HAN Architecture	Chelan & Douglas Counties	CDHD, CCIT, DCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Clallam County	CCHD, CCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Island County	ICHD, ICIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Grays Harbor County	GHHHS, GHCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Whitman County	WCHD, WCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Stevens County	NETCHD, SCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Cowlitz County	CCHD, CCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	
A-1	Implement HAN Architecture	Grant County	GCHD, GCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	
A-1	Implement HAN Architecture	Lewis County	LCPH, LCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	

Benchmark 12

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
A-2/BM 12	Develop Secure communication mechanism for Public Health emergency Response System	Finish configuration, procure Virtual Alert licenses, Develop business rules and training components for WA-SECURES	LHJ, WSHA, LRN, EMD, WASPC, Virtual Alert	Completion of initial development, licensing, training materials and processes	8-02
A-2/BM 12	Phase I Deployment of WA-SECURES	Deployment to DOH & LHJs	WSALPHO	Deployment in 90% of LHJs	11-02
A-2/BM 12	Phase II Deployment of WA-SECURES	Deployment to Hospitals	WSHA, LHJs	Deployment in 90% of hospitals	2-03
A-2/BM 12	Phase II Deployment of WA-SECURES	Deployment to Emergency Management Agencies	EMD, WSEMA	Deployment to State EMD and 90% of local EMDs	4-03
A-2/BM 12	Phase IV Deployment of WA-SECURES	Deployment to Laboratory Response Network	CLAC	Deployment to 90% of Level A, B, & C Laboratories	6-03
A-2/BM 12	Phase V Deployment of WA-SECURES	Deployment to Local Police, Fire, and EMS Agencies	Local EMD, WASPC, EMS Councils	Deployment to 90% of local first responders	8-03

Benchmark 13

Develop an interim plan for risk communication and information dissemination to educate the public regarding exposure risks and effective public response.

When will the interim plan be activated?

The Washington State Department of Health (DOH) has developed comprehensive emergency communications strategies, channels, and partnerships to provide interim emergency communications assistance to the public and support to the state's (local) public health system.

The DOH Emergency Communications Strategy will work in support of any existing local health jurisdiction (LHJ) emergency communication plans. (DOH will provide additional assistance to LHJs currently without emergency communications capacity.)

The DOH Emergency Communications Strategy will be activated during Level 2 or Level 3 public health emergencies. Public health emergency response will be initiated by the Secretary of Health or designee.

Level 2 Emergency – Local or statewide public health emergency requiring coordination between DOH divisions or other local or state agencies, and stand-by, partial or full activation of state Emergency Operations Center (EOC). (Examples include significant communicable disease outbreak, radiation or hazardous material incident.)

Level 3 Emergency – Severe state or regional emergency requiring all resources to resolve and full activation of State EOC. (Examples include major earthquake or natural disaster, terrorist attack, bioterrorism event.)

Interim Plan Elements

1) The DOH Comprehensive Emergency Management Plan (CEMP) provides clear reporting and response structures to guide overall DOH response efforts in the event of a public health crisis, including:
   - Assessment and Response Team (ART) – Comprised of the Secretary of Health, and members of DOH Senior Management Team.
     - o ART assesses scope and character of emergency; manages overall response plan; notifies DOH staff, state and local agencies; appoints liaison personnel to state Emergency Operations Center, and other agencies and jurisdictions as necessary.

2) Working in concert with the CEMP, the **DOH Emergency Communications Strategy** provides detail for media, Web, public and partner response including mobilization of resources to provide integrated system response coordination. When a *Level 2* or *Level 3* emergency is called, the Communications Director (or designee) enacts DOH Emergency Communications Strategy. At that time, the Communications Management Team will assume emergency assignments as follows:

- ▪ *Communications Director (or designee)* serves with Secretary of Health as a member of ART. Primary duties include:
  - o Media and issues planning and management as part of ART.
  - o Priority media response.
  - o Coordinate key messages for Secretary of Health and ART.
  - o *Key contacts – Governor's Communication Office.*

- ▪ *Media Manager (or designee)* serves at the State EOC. Primary duties include:
  - o Media and issues management and response as part of EOC.
  - o Priority media response.
  - o Coordination of media/key messages for DOH staff serving at EOC including State Health Officer and DOH Director of Risk Management.
  - o Ensuring consistent public health messages in EOC products.
  - o Ensuring DOH news releases and priority messages distributed throughout local emergency management agencies as appropriate (through state Emergency Management Division).
  - o **Key contacts** *– State/local emergency response partners including State Emergency Management Division, State Patrol, Department of Transportation, and other state/local agencies as applicable.*

- • *Web and Publications Manager (or designee)* serves at the DOH Communications Office. Primary duties include:
  - o Media and issues management.
  - o Activation of Communications Office emergency phone system, media alerts, Web messages, broadcast faxes and DOH staff and system e-mails.
  - o Activation of DOH Emergency Communications Roster.
  - o Management and assignment of information resources including: Public Information Officers, DOH Web Team, Emergency Communications Roster staff.
  - o Media and public information coordination including call prioritization, news releases, information requests, division contacts and resources, broadcast fax, listserv e-mail messages and Web plans.
  - o **Key contacts** *– DOH employees, local health jurisdiction and system (including designated hospitals and regional medical centers), Tribal Governments, CDC Communication Office, National Public Health Information Coalition, and auxiliary state agencies such as Department of Information Services.*

In coordination with the Communications Office Management Team and incident-related DOH divisions, DOH Public Information Officers, Web Team, and Emergency Communications Roster staff will assume emergency assignments including:

- • *Media Response Coordination* – Track and log all media calls, inquiries and response efforts; record key and emerging issues, answer staff and LHJ inquiries regarding status of interviews, information distribution efforts, and issues.

- • *Public Information Officers and Emergency Communications Roster staffing* – Create or distribute news releases, talking points, background information, fact sheets and other materials as assigned. Respond to general inquiries from media/staff/LHJ/public health

and system partners. Provide division/program and LHJ media assistance as needed. Provide research assistance.

- *Web Management* – Coordinate employee communications (intranet), media and general public messages (internet), and LHJ/provider/emergency responder alerts and information (internet). Ongoing Web updates and message maintenance. Work with DIS in the event of DOH Web server failure.

- *Administrative staff support* – Broadcast fax news releases and other information, as appropriate, to state media list, LHJs, and designated hospitals/regional medical centers; materials preparation support; general inquiries; other duties as assigned.

Communications Office/Emergency Plan Logistics:

- The emergency communications plan will be coordinated from the DOH Communications Office in Olympia.

- Emergency media hotline system is in place with all Communication Office lines streaming to one number when activated. (Additional lines as needed.)
    - o Existing Communications Office phone numbers will automatically transfer to central hotline.
    - o Central hotline number will be distributed to media, LHJs, partners.

- Plan in place to move Communications Office phones and functions to different building if security/integrity of current location is threatened.

- Emergency Web posting agreement with DIS in the event of DOH server failure.

- If necessary, DOH emergency communications staff—on limited priority basis—can be deployed to affected region (LHJ or Joint Information Center).

Related Support Systems and Materials
- DOH maintains a Bioterrorism Web site with specific links and resources for: General Public; LHJ/Healthcare Providers; and Emergency Responders. (Includes links to information for general public in Spanish.)
- Of 34 LHJs, 29 have Web sites. (Public Health-Seattle & King County has an extensive Web site, with specific bioterrorism resources.) DOH Web maintains map with current links to all LHJ sites.
- DOH has prepared fact sheets on agents of potential bioterrorist threat and emergency planning, and offers LHJs Risk Communication/Media training.
- Listservs: For rapid dissemination of essential materials include – LHJ-HO@listserv.wa.gov (local Health Officers); WACOMDIS@listserv.wa.gov (from Office of Communicable Disease Epidemiology); WSALPHO@listserv.wa.gov (public health system).
- LHJs have relationships with special populations, specific communities, local agencies and organizations within their jurisdictions. DOH will assist—as necessary in evaluating/coordinating public information dissemination.
- List of key LHJ spokespeople identified.

Benchmark 14

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
14	Develop regional plans to meet learning needs through multiple sources	Participate in assessment development process described in Focus Area A, Section II Benchmark #3, to determine best approach to include learning needs for emergency department personnel, infectious disease specialists, public health staff and other health care providers as part of the second phase.	UW NW Center for PH Preparedness, DOH training liaison, stakeholder committee, assessment development committee, *LINK to HRSA assessment*	Timeline for second phase of assessment focused on learning needs	5/02-6/02
		Develop learning needs assessment process and tools that measure competency strengths, gaps and barriers.	UW NW Center for PH Preparedness, DOH training liaison, assessment development committee	An assessment instrument template and process	9/1/02
			Regions/DOH Liaison	Pilot test in 3 regions	10/30/02
		Implement learning needs assessment		Conduct assessment	1/31/03
		Analyze results	Regions	Identify competency strengths, gaps and barriers

Prioritize needs and recommend improvements and ways to build on strengths

Incorporate into updated regional educational plans | 2/28/03 |

Focus Area A: Preparedness Planning And Readiness Assessment
Section I.   Strategic Direction, Coordination and Assessment
Critical Capacity A

Establish a process for strategic leadership, direction, coordination, and assessment of activities.

Current Capacity:
Interagency collaboration. Washington State enjoys a history of interagency collaboration at the national, state and local levels. Two national public health association leaders are also Washington-based leaders: Mary C. Selecky is President-Elect of the Association of State and Territorial Health Officials (ASTHO) as well as Secretary of the Washington State Department of Health. Patrick Libbey is the President of the National Association of City and County Health Officials (NACCHO) and the Director of the Thurston County Public Health and Social Services Department. Both leaders are actively involved in national and state efforts to address bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. Both are long-standing and active members of the Washington State Association of Local and Public Health Officials (WSALPHO). Building on these and similar working relationships, state and local health leadership together, recently adopted a set of guiding principals to direct the work plans and activities called for in this Cooperative Agreement.

Unfortunately, Washington State has experience with many diverse natural disasters, such as last year's earthquake and the 1980 eruption of Mount St. Helens. In addition, the Hanford Nuclear Reservation is located in Richland, Washington, and just across Washington's southern border is the Chemical Depot at Umatilla, Oregon. To prepare for and to address potential natural, radiological and chemical disasters, Washington State recently built a state-of-the-art emergency operations center. This center is supported by county-based efforts statewide.

The University of Washington's Northwest Center for Public Health Practice has recently been designated a Center for Public Health Preparedness. This will continue to be a valuable resource to Washington and all the states in our region.

Determination of Adequacy:
While Washington State is prepared on many levels to address natural, radiological and chemical disasters, it does not possess the capacity at state, regional and local levels to address every potential biological threat. Local public health districts need to build capacity such as staffing, communications, and equipment. Existing local emergency plans must be expanded and coordinated with local public health districts, local hospitals, emergency management services and other emergency responders. Local plans need to "roll up" to regional plans, and regional plans need to "roll up" to state plans.

Proposed Improvements:
A process is being developed to establish strategic leadership, direction, coordination and assessment of activities:

1. **Executive Director:** Mary C. Selecky, Secretary of the Washington State Department of Health, will serve as the executive director of the bioterrorism preparedness and response program.

2. **Advisory Committee:** The Bioterrorism Response Advisory Committee is representative of our diverse public and private partners (for a member roster, see Benchmark #2, page 44). The Advisory Committee is established to:
    - Carry forward the goal of the state's emergency planning to create a plan to prepare for and respond to public health threats and emergencies (as per section ESF-8 of the state emergency plan) – particularly our preparedness and response to infectious disease. Links to the Governor's Washington State Committee on Terrorism (COT) will be maintained through dual committee membership among select members.
    - Proactively serve as an information conduit to communicate and educate members' respective stakeholders on state plan development, expectations and needs.
    - Advise the agency on progress toward state plan implementation. This will include identifying gaps and trouble spots, lessons learned, significant innovations, successes, and opportunities, as well as providing possible solutions to problems and barriers to implement a state plan.
    - Advise the agency on coordination of Advisory Committee efforts with other state efforts, including the work of the Governor's Washington State Committee on Terrorism (COT), all intended to address public health emergencies related to bioterrorism, infectious disease outbreaks, and natural or man-made disasters.

3. **Regular updates:** Policy makers, elected officials and Advisory Committee members will be provided regular updates about preparedness activities through: a) Regular reports, b) Two, in-person meetings of the Advisory Committee per cooperative agreement year, and c) Regularly scheduled briefings by electronic communication.

4. **Coordinated process for monitoring progress**: In concert with state, regional and local stakeholders, DOH staff members will monitor the progress and performance of the Bioterrorism Preparedness and Response Program (the "Program"). The following key steps will be implemented:
    a) Program objectives, activities, and quantifiable milestones will be used to guide, measure and track planning progress.
    b) Program implementation will be monitored across all planning activities and all involved and contributing partners.
    c) DOH management and Bioterrorism Response Advisory Committee members will demonstrate a commitment to deploying the plan through regular communication with those directly affected by bioterrorism preparedness and response plans.
    d) Potential barriers to deploying the Program will be identified through Bioterrorism Response Advisory Committee plan review, discussion and feedback. Two-way communication will be put in place to ensure effective stakeholder feedback and participation.
    e) Program deployment activities–milestones–will be documented and reviewed. This will include monthly and semi-annual reports that will summarize progress toward accomplishing program goals by objectives, activities, timelines and status. Gaps and

trouble spots, lessons learned, significant innovations, successes, opportunities, and achievements will be noted.

       1) Monthly reports will be provided to Program staff members (state, regional, and local health) and a Bioterrorism Response Steering Committee comprised of key internal and external stakeholders.

       2) Semi-annual reports will be provided to all program participants, interested members of the public and the CDC.

  f) The Program will be measured against original planning goals. This will include estimated costs and timelines versus actual costs and timelines, and the potential value of a proposed improvement (return on investment, potential for performance improvement) versus possible deployment risks.

  g) A formal comprehensive evaluation plan will be developed and implemented for planning activities beginning in September 2003 if future funds are provided for evaluation. Program leadership will draw upon CDC and The Northwest Center for Public Health Practice (NWCPHP) for evaluation expertise.

1. **Conferences and workshops:** To ensure state and local readiness, interagency collaboration and preparedness, planning partners and stakeholders will be encouraged to participate in breakout and keynote sessions to be held in conjunction with existing statewide public health conferences. The Washington State Department of Health will partner with existing statewide conferences such as the Washington State Joint Conference on Health, the Washington State Rural Health Association Conference and the Washington State Association of Local and Public Health Officials' (WSALPHO) Conference. It is anticipated that conference and workshop topics will focus on Washington's Bioterrorism Preparedness and Response Program – Program objectives, activities, and milestones, plus, as details emerge, specific coverage of gaps and trouble spots, lessons learned, significant innovations, successes, opportunities, and achievements. Conference and workshop planners will also be encouraged to draw on institutional and professional resources such as those highlighted by the CDC's Public Health Practice Program Office in its March 19, 2002 document, *Summary of Available Resources: Bioterrorism Preparedness and Response Program.* This includes consultation with the CDC's Public Health Practice Program Office (PHPPO) and the National Center for Infectious Diseases (NCID).

   Conference and workshop activities will be integrated to Focus Area G[*] activities to incorporate learning delivery systems.

2. **Inclusion and participation of health partners not directly involved in bioterrorism preparedness:** The success of a state preparedness strategy relies on the ability of all levels of government and the private sector to communicate and cooperate effectively with one another. Communication and cooperation will be bolstered through myriad means including conferences, publications, and regular meetings of entities such as our public health officials' organization, EMS/Trauma councils, and the Governor's Washington State Committee on Terrorism (COT). As more fully described in section II of Focus Area A (page 52), the

---

[*] Focus Area Integration

Washington State Department of Health is committed to engaging the full range of public health partners in our planning efforts.

To promote the effective implementation of Washington's Bioterrorism Preparedness and Response Program at the interfaces of state and local public health departments, the Washington State Department of Health has adopted goals and principals for operation (see Documentation of Local Involvement). It also endorses the *Principles of Collaboration Between State and Local Public Health Officials* as adopted by the Joint Council of State and Local Health Officials on February 2000.

The Washington State Department of Health proposes to establish meaningful and effective partnerships with tribal governments, and Washington's Hispanic and Asian communities. Initially this will be accomplished through the participation of these populations on Program task forces and the Bioterrorism Response Advisory Committee. The needs of participating tribes and Hispanic and Asian communities will be addressed at the local and regional planning level, through integration in the local emergency response plans. Cultural and linguistic factors will be a part of risk communications and education and will be included in Program planning efforts under Focus Areas F and G. [*]

3. **Training and career development activities:** Project leadership training and career development is crucial to ensuring the successful implementation of Washington's Bioterrorism Preparedness and Response Program. The Washington State Department of Health will provide $25,000 to The Northwest Center for Public Health Practice (NWCPHP) to help support the creation of a regional, six-state, "Northwest Bioterrorism Leadership Institute." The NWCPHP expects to use the Public Health Preparedness curriculum developed by the Center for Public Health Preparedness at St. Louis University to develop technical, managerial and leadership competencies for those in the workforce with responsibility for public health preparedness and response. The recent designation of the University of Washington's Northwest Center for Public Health Practice as a Center for Public Health Preparedness will enhance our training and career development activities.

Training and career development activities will be incorporated with Focus Area G[*] activities.

The Washington State Department of Health will continue to build on existing training efforts such as the tabletop learning activity, *Hands-on Training for Public Health Emergencies*, to help promote the interagency collaboration and cooperation necessary to prepare for, and respond to, a major disease outbreak or bioterrorism event.

The Washington State Department of Health in early April 2002 jointly sponsored with the NWCPHP and the Washington State Public Health Association presentations by Dr. Vincent Covello, Director of the Center for Risk Communication. Similar training opportunities will

---

[*] Focus Area Integration

continue to be sponsored by DOH to improve public health professionals' response to bioterrorism and other public health threats and emergencies.

Focus Area A, Section I, Critical Capacity A
Work Plan Timeline

Capacity A	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
Activity #1	Establish strategic leadership and direction	Designate a senior public health official to serve as executive director of the bioterrorism preparedness and response program.	Organizations represented on the Bioterrorism Response Advisory Committee (BRAC)	Appoint executive director.	**DONE.** Mary C. Selecky appointed March 2002
Activity #2	Establish strategic leadership, direction, coordination	Establish the BRAC and a working charter. Provide member roster.		Prepare BRAC Working Charter. Complete roster.	**DONE, adopted.** March 3, 2002 **DONE, complete.** April 5, 2002
Activity #3	Ensure regular updates on preparedness activities	Establish a communication system and schedules for regular updates.		Contact information established for electronic and hard copy communications. Schedule established for regular reports (monthly, semi-annually).	May 31, 2002 May 31, 2002
Activity #4	Establish a process for monitoring progress	Use the workplan timeline in concert with the CDC-approved cooperative agreement narrative to create a formal PERT chart tool for documenting/monitoring progress and performance of all Program elements.		PERT chart tool and process approved and implemented.	June 30, 2002
Activity #5	Partner/participate in conferences, workshops.	Seek partnering opportunities with current sponsors of statewide public health conferences. Compile a list of possible topics and potential speakers. Compile a list of possible conference and workshop attendees.	WSPHA	Potential partners identified and contacted. Topic list and speakers identified. Partner and stakeholder group contacts identified as well as notification, communication channels.	July 31, 2002 July 31, 2002 July 31, 2002

Capacity A	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
Activity #6	Ensure systemic planning and implementation of cooperative agreement activities.	Identify parts of the public health system not directly involved in bioterrorism preparedness.	LHJs WACMHC	List created of all public health system parties affected by planning activities.	August 30, 2002
		Identify communication channels.		Contact points, communication channels established.	August 30, 2002
		Identify planning activities for participation and implementation by all stakeholders, interested parties.		Planning activities of broad interest identified.	August 30, 2002
Activity #7	Establish training and career development activities for project leadership.	Expand and "grow" existing training efforts.	NWCPHP	At least ten more stakeholder groups participate in the existing tabletop learning activity.	May 30, 2003
		Cooperatively work with the University of Washington to establish the Northwest Bioterrorism Leadership Institute.		Formal partnership established.	August 30, 2002
				St. Louis University curriculum reviewed, modified, tested.	September 30, 2002
				First Institute workshop, class held.	November 30, 2002

Focus Area A, Section I, Critical Capacity A, <u>Benchmark 1</u>

Mary C. Selecky will serve as the executive director of the Bioterrorism Preparedness and Response Program. <u>APPOINTED March 2002</u>

Executive director duties:
- Chair the Bioterrorism Response Advisory Committee.
- Clarify the goal and purpose of the Bioterrorism Preparedness and Response Program (the Program).
- Take responsibility for overall Program direction and oversight
- Select Program participants (stakeholder involvement and staffing) through a transparent process.
- Provide ongoing guidance to all Program stakeholders and staff.
- Ensure effective organizational planning.
- Manage resources effectively.
- Ensure Program evaluation and monitoring of the proposed programs and services.
- Provide support for the Program's public image and communication links to stakeholders.

Executive Director Curriculum Vitae

Mary C. Selecky
Department of Health
1112 S.E. Quince Street
Olympia, WA 98504-7890
mary.selecky@doh.wa.gov
360-236-4030   Fax 360-586-7424

<u>Secretary of Health – March 15, 1999 to Present</u>
Washington State Department of Health, Olympia, Washington

<u>Acting Secretary of Health – October 5, 1998 to March 15, 1999</u>
Duties: Provide leadership for the Washington State Department of Health in fulfilling its responsibilities of protecting and promoting public health. Manage a cabinet-level agency of 1,200 staff with a biennial budget of $500,000,000.

<u>Administrator – January 1, 1979 to March 15, 1999</u>
Northeast Tri-County Health District, Colville, Washington
Duties: Provide administrative duties and leadership for a three-county public health district serving Ferry, Pend Oreille and Stevens Counties with 45 staff and a $2.2 million budget.

<u>Previous Work Experience</u>
Interim Director – December 1, 1986 to August 1, 1988
Stevens County Counseling Services, Colville, Washington
Duties: Provide interim management leadership for county agency which provided mental health, drug, alcohol and contracted developmental disability services.

<u>Administrative Assistant/Administrator – February 1975 – December 31, 1978</u>
Trico Economic Development District, Colville, Washington
Duties: Supervised staff and projects for a three-county economic development district according to the annual Overall Economic Development Plan.

<u>Assistant Dean of Students – September 1971 – April 1974</u>
University of Pennsylvania, Philadelphia, Pennsylvania
Duties: Supervised all student activity organizations and new student orientation, prospective student recruitment and interviewing.

<u>Assistant Director of Student Life & Environment – September 1971 – April 1974</u>
Sarah Lawrence College, Bronxville, New York
Duties: Supervised and responsible for all housing assignments, student counseling and activities; interviewed and recruited prospective students; coordinated community events at the college.

<u>Education:</u>   1969, BA, History & Political Science, University of Pennsylvania

Honors:
1987   Washington State Public Health Association Annual Award, Association for
            Sexuality and Training Merit Award
1993-1999   National Association of County Health Officials (NACCHO) Award of
            Appreciation
1995-1997   Washington State Rural Health Association – Outstanding Contribution to Rural
            Health Award
1993-94   National Public Health Leadership Institute Scholar

<u>Selected Organizations and Affiliations (Current):</u>
Association of State and Territorial Health Officers (ASTHO) (president-elect)
Washington Rural Health Association
Public Health Leadership Society
Washington State Public Health Association
American Public Health Association
American Association of University Women
Rotary International
Northeast Washington Rural Resources Board of Directors (member emeritus)
Washington Governmental Entity Pool (member emeritus)

<u>Past Organizations and Affiliations:</u>
Co-chair Governor Gary Locke's Transition Team Health Roundtable
Co-chair Governor Mike Lowry's Roundtable on Federal Reductions
Public Health Improvement Plan Steering Committee
American Indian Health Care Delivery Plan Advisory Committee
Stakeholders Committee of Washington Health Services Commission
Technical Advisory Committee Member for Basic Health Plan Commission and
Washington Health Care Commission
Washington Rural Health Commission
Past Chairman, DSHS Medical Assistance Advisory Committee
National Association of City and County Health Officials (former board member)
Washington State Association of Local Public Health Officials (former chair & board member)
N.E.W. Health Programs Board of Directors

<u>Academic Presentations:</u>
Clinical Associate Professor, School of Public Health, University of Washington, Gonzaga
University School of Nursing, topic: Leadership
Western Washington University, topic: Leadership
Public Health Leadership Institute, topic: Political Leadership
Southeast States Public Health, topics: Leadership, Public Health Systems Improvement and
Core Functions
Illinois Public Health Leadership Institute, topic: Rural Health

Focus Area A, Section I, Critical Capacity A, Benchmark 2

a) Charter of the Bioterrorism Response Advisory Committee DRAFT ADOPTED 3/5/2002

Working Charter Bioterrorism Response Advisory Committee

Background: The Bioterrorism Response Advisory Committee consists of partners and representatives of stakeholder groups that are committed to creating a plan to prepare for and respond to public health threats and emergencies (as per section ESF-8 of the state emergency plan). This includes a response to bioterrorism and outbreaks of infectious diseases through comprehensive planning, training and evaluation. The U.S. Department of Health and Human Services (CDC and HRSA) is funding this planning effort through cooperative agreements with the Washington State Department of Health (DOH) beginning in February 2002.

Proposed membership: *(see the following roster)*

Roles and Responsibilities: The Advisory Committee has an advisory relationship found in the State of Washington's formal plan, "The Bioterrorism Preparedness and Response Program." It is responsible to:

5. Carry forward the goal of the state's emergency planning to address and enhance ESF-8, particularly our preparedness and response to infectious disease.

6. Proactively serve as an information conduit to communicate and educate members' respective stakeholders on state plan development, expectations and needs.

7. Advise the agency on progress toward state plan implementation. This will include identifying gaps and trouble spots, lessons learned, significant innovations, successes, and opportunities, as well as providing possible solutions to problems and barriers to implement a state plan.

8. Advise the agency on coordination of Advisory Committee efforts with other state efforts, including the work of the Governor's Committee on Terrorism, to address public health emergencies related to bioterrorism, infectious disease outbreaks, and natural or man-made disasters.

Meeting Process: It is anticipated that the Advisory Committee Chair will convene the Advisory Committee no more than twice annually. Meetings will be held in either Olympia or the Puget Sound area. Travel expenses for members will be reimbursed upon request. The Washington State Department of Health (DOH) will provide meeting staffing support. The majority of Advisory Committee communication and work will be conducted via electronic mail (e-mail).

Critical **Benchmark #2**

b) Roster of the Bioterrorism Preparedness and Response Program Advisory Committee.
COMMITTEE MEMBERS APPOINTED AND IN PLACE AS OF APRIL 5, 2002.

State Department of Health
Mary Selecky, CHAIR
Secretary, Washington State Department of
    Health

Local Health Departments
M. Ward Hinds, MD
Chair, Washington State Association of Local
    Public Health Officials (WSALPHO)
Health Officer, Snohomish Health District

Alonzo Plough, PhD
Director and Health Officer, Seattle King County
    Pubic Health District

Washington State Emergency Management
    Association
Ed Reed
Program Manager,
Pierce County Department of Emergency
    Management

Emergency Medical Services
Brian Hurley
Chair, EMS Committee
Washington State Council of Firefighters

Office of Rural Health
Laurie Wylie
Executive Director, Western Washington Area
    Health Education Center (AHEC)

Area Health Education Center (AHEC)
Steven Meltzer
Director, Area Health Education Center at
    Washington State University

Fire Department
Gary Aleshire, Chief
Medical Services, Lakewood Fire Department
Washington State Fire Chiefs Association

Washington Association of Coroners &
    Medical Examiners
Dan Blasdel
President, WACME
Franklin County Coroner

Emergency Rescue Workers
Mike Turay

Mason County Medic One
Washington Ambulance Association (WAA)
Occupational Health Workers
Lee Glass, M.D.
Washington State Department of Labor and
    Industries

Washington State Department of Agriculture
Diane Dolstad, Program Manager
Animal Health, Food and Diary Laboratory

University (medical)
Walter E. Stamm, M.D.
Professor of Medicine, Department of Medicine
University of Washington

University (public health)
Mark Oberle, M.D.
Associate Dean for Public Health Practice
Professor of Health Service and Epidemiology
School of Public Health and Community
    Medicine
University of Washington

University (veterinary school)
Terry F. McElwain, D.V.M., Ph.D.
Professor and Executive Director, Washington
    Animal Disease Diagnostic Laboratory
Director, Animal Health Research Center,
    College of Veterinary Medicine,
Washington State Univ.

Community Colleges
Jim Crabbe
Senior Administrator, Workforce Education
State Board for Community and Technical
    Colleges
Washington Association of Community and
    Migrant Health Centers
Gloria Rodriquez, CEO
Washington Association of Community and
    Migrant Health Centers

Red Cross
Bev Ritter
American Red Cross of Snohomish County

Hospitals – Veterans Affairs
Les Burger, M.D.
Acting Director,
Veteran's Integrated Service Network (AK, OR, WA, ID)

Hospitals – Military
Brig. General Ken Farmer
Madigan Hospital

Hospitals – Public/Private
Gordon McLean, Hospital Administrator
Mount Carmel Hospital

Mount Carmel Hospital
Gordon McLean, CEO

Northwest Hospital
Peter Rigby,
Director of Therapies

Washington State Nurses Association
Louise Kaplan, PhD
President, WSNA

Washington State Medical Association
Nancy Auer

Tribal
Joe Finkbonner
WSMA, Past President
Director, Northwest Tribal Epidemiology Center
NW Portland Area Indian Health Board

Washington State Clinical Laboratory Advisory Council
Stephen Sarewitz, M.D.
Valley Medical Center

Washington State Pharmacy Association (WSPA)
Rod D. Schaffer
CEO, WSPA

Washington State Psychological Association
Lucy Homans, Ed.D.

Legal
Kathleen D. Mix
Chief Deputy Attorney General

Law Enforcement
Bill Hanson
Executive Director, Washington Council of Police & Sheriffs

Alternate:
Washington State Hospital Association
Brenda Suiter,
Director, Rural and Public Health Policy

Critical Capacity B

Conduct integrated assessments of public health system capacities related to Bioterrorism.

Existing capacity

There is no single entity or program in existence in the state to develop, conduct, and analyze public health capacities related to bioterrorism and other emergencies. Federally sponsored assessments recently completed did not adequately measure statewide capacities, although they did reveal significant gaps in preparedness. Surveillance and epidemiological capacity is very limited and is unevenly distributed in the state (see Focus Area B[*]). Health care providers are not well trained to identify and rapidly report suspicious syndromes. Planning for communicable disease and mass casualty events is limited. In some cases public health, hospitals, public safety, and emergency services staff are not well-acquainted and do not have a solid understanding of each others' roles in such events. Nor are we sure that the public health policies address the needs of the communities in the state. Absent grant funding, a renewed assessment effort would require diversion of existing resources away from other activities.

Determination of Adequacy

The current capacity to assess the bioterrorism preparedness and response needs of the state is not adequate. The federally sponsored Public Health Emergency Preparedness Assessment (PHEPA) was not designed to yield data that fully describes critical public health capacities in our state. For example, an affirmative answer to many questions was garnered even if work on the subject issue had merely been started. This gave the false impression that a complete capability existed when, in fact, there was practically none. The needs of large metropolitan areas such as Seattle and King County as well as counties neighboring Portland, Oregon and Vancouver, B.C. have not been assessed in the context of a comprehensive state system

Use of borrowed existing resources cannot reasonably be expected to result in the analysis needed. Moreover, other important public health functions would necessarily suffer as their resources are diverted to the assessments.

Proposed Improvements

Conduct comprehensive capacity assessments covering the broad areas of
- hospital preparedness[†] (using the assessment required by HRSA grant funding)
- public health system preparedness (epidemiology, surveillance, laboratory, policies, infectious disease outbreaks, vaccinations etc)
- emergency management system integration (including related public safety disciplines)
- public health policy (reviewing ordinances, county codes, mutual aid agreements, and State Board of Health rules)

It is essential that a solid assessment of existing capacities and needs be completed in the very near term. This assessment and the process used to conduct the assessment will be based on an

---

[*] Focus Area Integration
[†] CDC – HRSA Coordination

50

analysis of data gathered to this point. Therefore, a critical starting component will review the results of existing assessments, including the PHEPA.

The fundamental approach will be determined once the partners have convened and the regional concept has been accepted. This process will be coordinated by a manager temporarily detailed to this effort. For the assessment of legal authorities, the state Department of Health will use up to twenty-five percent of the time of an existing manager/attorney for up to ten and one half months. This manager will work with an Assistant Attorney General and the State Board of Health to examine current legal authorities, identify gaps, and recommend adjustments.

The analyzed data from the assessments will form the basis for the development of local, regional, and state contingency plans to address identified shortfalls (see Focus Area A, Section II, Critical Capacity A).

At a minimum, assessments will require the participation of officials from each of the following disciplines:

- Public Health (including urban and rural jurisdictions)
- Hospitals[*] (including federal facilities)
- Emergency Medical Services
- Emergency Management
- Law Enforcement
- Fire Protection
- Medical Examiners/Coroners
- Tribal representatives
- Military (federal and national guard)
- Private health care providers
- Volunteer organizations
- Legal services

Assessments will be constructed to provide data on (at a minimum):
- available equipment (PPE, radios, etc)
- existing plans
- mutual aid agreements
- established relationships or assigned responsibilities
- staff skills
- staff availability
- training
- surge capacity
- laboratory resources
- public health policy issues
- immunizations
- epidemiology/surveillance

---

[*] HRSA – CDC Coordination

- vaccine storage, distribution and tracking
- special populations including tribes, ethnic populations
- issues of major metropolitan areas such as Seattle.
- jurisdictional issues including neighboring states or counties

The assessment tool will be developed using existing instruments as models, including the *Tool for Rapid Assessment* developed by CDC. It is anticipated that assessments of public health, public safety (including emergency services), and hospitals will be implemented using a comprehensive tool. Assessment of legal authorities will likely be accomplished separately. Existing data and questions from recently used assessments will be used to facilitate the process. Experience indicates that a facilitated process yields the best, most consistent data. To that end, regional staff will be used to aid local jurisdictions in the completion of the assessment.

In order to provide the most useful data, assessment results will "roll-up" from the local level, through the regional level, to the state level. The special needs of the major metropolitan area of Seattle will be assessed. Counties bordering Portland, Oregon and Vancouver,B.C., will be considered in the context of developing one comprehensive public health system. Coordination and collaboration with special populations, tribes, jurisdictions and/or neighboring states and counties will be accomplished in the state, regional and local planning processes following this assessment. The result will be a comprehensive written report that details the findings of the assessment effort. This report will be provided to elected and appointed officials who have oversight of public health activities.

Focus Area A, Critical Capacity B, <u>Benchmark 3</u>
Assessment of Public Health System Capacities Related to Bioterrorism

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
Area A, Section I, Benchmark #3	Develop State-wide and Regional plans to respond to bioterrorism and other emergencies	Conduct an integrated assessment of the public health system capacities related to bioterrorism, infectious disease outbreak and other public health threats Review existing county emergency plans for inclusion of PH/ ESF-8	LHJs, hospitals[*], emergency management agencies and first responders (fire, law)	Project leader and support staff are identified Key stakeholders committee for needs assessment development is established	April 30, 2002
	Develop Assessment Tool	Convene assessment development committee Determine assessment scope and boundaries, requirements and fundamental approach (Self audit, team approach or a combination of both) Work with IT staff to design mode of administration and needed security measures Coordinate with HRSA group[*] to identify redundancies or additional questions needed Develop form		Assessment tool is developed	April 30, 2002
	Test Assessment tool	Peer review Field test		Testing of tool is complete	May 31, 2002
	Train Assessment team	Select, develop program and train assessment implementation team		Team is assembled and trained	June 30, 2002
	Implement needs assessment tool	Regional staff conduct assessments in each county		Assessments completed	July 31, 2002

---

[*] CDC – HRSA Coordination

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
3	Analyze data results	Review results and engage in any further discussion as necessary Identify gaps or needs Make recommendations Consider budgetary implications Prioritize needs Implement capacity building program			August 15, 2002
	Publish and disseminate assessment results	Data is compiled in useful formats Report is drafted Legal review for protection from public release	Attorney General	Report is published and disseminated	September 1, 2002

Focus Area A, Critical Capacity B, Benchmark 4

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
4	Assess and improve existing state statutes and regulations	Identify state statutes and regulations which could be strengthened and clarified, including those relating to (1) credentialing and licensure, (2) authority for executing emergency health measures, and (3) addressing liability of health care personnel Clarify the emergency authorities of local health officers, including quarantine and isolation, establish due process protections in rule, and enhance enforcement of emergency actions.	AGO, EMD, SBOH, WSALPHO, LHJs, Law enforcement, Legal Counsel for LHJs , Judiciary (e.g., Judges Association/ Administrator for the Courts), Civil Liberties Groups (e.g. ACLU/Columbia Legal Services)	Establish a representative group to review existing assessments, conduct gap analysis, and identify emergency authorities to be strengthened and clarified Prepare a report on the assessment of existing state statues and regulations, draft a plan for the enforcement of emergency orders and the process of protecting civil liberties, and distribute to state and local agencies and elected officials responsible for oversight and improvement of health agencies' legal authorities Revise rules pertaining to emergency powers and duties of local health officers	5/02 9/02 (for any recom-mended statutory changes) & 12/02 (for recommen ded rules) 1/03
4	Assess local government legal authorities	Identify any local ordinances or county codes relating to emergency health powers	WSALPHO/LHJs, Legal Counsel for LHJs	Survey and gather local health ordinances and county codes relating to emergency health powers Establish a representative group to review and assess the ordinances and county codes Prepare a report for use by local governments to improve emergency health powers ordinances and codes	5/02 5/02 2/03

Focus Area A, Section II: Preparedness and Response Planning
Critical Capacity A

Respond to emergencies caused by bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies through the development and exercise of a comprehensive public health emergency preparedness and response plan.

Existing Capacity

At the state level and at many local jurisdictions, plans do exist that address health roles and responsibilities in a generic emergency event. In most cases where they do exist, they are encompassed in a Health and Medical Services annex (typically identified as Emergency Support Function #8) to the jurisdiction's Comprehensive Emergency Management Plan (CEMP). The state and many local jurisdictions have been able to work within the framework and guidance provided for in existing plans, responding adequately to the relatively small-scale emergencies that the state has so far experienced. The state Department of Health is well-experienced in participating in the existing multi-agency unified incident command structure that manages disaster events from the state emergency operations center.

The state emergency management agency, with input from the Department of Health, has drafted a terrorism annex to the state CEMP. This annex describes in very broad terms the state's approach to managing terrorism events, including bioterrorism.

The state Department of Health and many local health jurisdictions have emergency alert and notification procedures that are used to identify ways to contact appropriate entities at any hour.

Determination of Adequacy

This capacity is inadequate for a bioterrorism event. The State's plans do not adequately define roles and responsibilities as they pertain to communicable disease emergency events (including bioterrorism); nor do they adequately provide for mass casualty/mass fatality events. In most cases, the plans that do exist are not sufficiently detailed, providing instead broad descriptions of approaches and responsibilities. These plans have never been tested in a large scale disaster or full-scale exercise.

Proposed Improvements

The development of an array of coordinated public health emergency plans at all levels that address more detailed descriptions and assignments of response activities at the local, regional, and state levels is proposed. These plans will:

- describe pre-event mitigation and preparedness activities
- describe response to communicable disease emergencies
- emphasize the unique requirements of a bioterrorism event
- describe the management of mass casualty and mass fatality events
- be coordinated with hospitals and other health care facilities
- conform with approved concepts of operation described in state and local comprehensive emergency management plans

- address the vulnerabilities and deficiencies identified in the emergency preparedness assessment addressed in Section I of this focus area.
- provide for regular testing and validation of those plans

In order to be most useful, comprehensive plans must be developed from the local level through the regions to the state level. That is not to say that all local plans must be final before work can begin on regional or state level plans. No plan at any level in the process will be developed in a vacuum. Plans will be coordinated and integrated both vertically and horizontally. Consensus on overall approach will be achieved to the highest extent possible. Substantial grant funds will be passed through to local jurisdictions to provide each jurisdiction with resources to develop emergency plans. Local health jurisdictions will be required to coordinate plan development with their local emergency management agency.

An important early part of the planning process is the completion or updating of hazard identification and risk and vulnerability assessments per standard FEMA planning doctrine. Understanding the risk a community or region faces and comparing it with the capacities identified will reveal gaps that may at least partially be addressed through planning decisions.

Regionalization. In the state of Washington public health services are delivered through 34 local health jurisdictions. We propose organizing these LHJs into ten Public Health Regions. Our two largest LHJs, Public Health Seattle & King County and Tacoma-Pierce County Health Department, will each encompass one region. The remaining 32 LHJs will be assigned to one of the remaining eight regions. A lead LHJ will be designated for each of these regions. These LHJs will be provided with increased funding specifically to carry out regional activities.

All LHJs will designate an emergency response coordinator and will be funded to develop coordinated plans that are integrated with and support the plans of other agencies and entities, particularly hospitals[*] and (if applicable) MMRS. By the end of the performance period, all LHJs will have a 24/7 notification and activation protocol (see benchmark #12, Focus Area E[†]).

The Public Health regions will be closely aligned with the state's existing EMS and Trauma Care regional councils. These councils include hospitals[*], emergency medical services providers, local government, consumers, and others. Representatives from the Public Health Regions will be included in these existing councils to ensure coordination. Likewise, hospital and EMS entities will participate in the development of local and regional plans.

Regional planners will provide technical assistance to local health jurisdictions as they develop their local plans. Mutual aid is an important concept to ensure effective use of limited response resources. Regional planners will, therefore, also develop plans for sharing of resources within the region as well as with other regions in the state. State plans will provide for the statewide management of shared resources.

Four state field staff will provide technical assistance and guidance to regional and local planners. Their work will start with reviews of existing plans and procedures at all levels. To ensure consistency and adequacy across the statewide public health response system, local and

---

[*] CDC – HRSA Coordination
[†] Focus Area Integration

regional plans will be subject to approval from the state Department of Health. All plans will be coordinated and consistent with the larger emergency management system, including hospitals,[*] emergency medical services,[*] law enforcement, and fire protection districts.

The state's Secretary of Health will appoint a Special Assistant who will serve as the lead coordinator for the state's Bioterrorism Preparedness and Response Program. He/she will have oversight responsibility for the development and implementation of planning activities associated with this cooperative agreement, including the coordination of assessment activities of hospitals and emergency medical services[*] funded separately from this cooperative agreement.

The Office of Risk Management will continue to serve as the agency lead for emergency planning. Grant funds will be used to hire two additional state planning staff for this office to update and improve Emergency Support Function #8 to the state's Comprehensive Emergency Management Plan, to coordinate the revision to the agency's internal emergency plans and procedures, to continue work on the Pharmaceutical Stockpile Plan, to train state DOH staff, and to develop and conduct exercises. These staff will also be involved in providing technical assistance and grant oversight. A manager will supervise these planners and the four field technical staff. This group will form the core of dedicated emergency preparedness and response staff.

Grant funds will also be used to provide planning assets for each of the following areas within the Department of Health's divisions: communicable disease epidemiology, health systems, environmental health, and immunizations. In addition to the usual coordination with state and local partners, all planning will be carried out in collaboration with appropriate federal agencies.

The state Department of Health Immunization Program will develop a plan to promote immunizations to mitigate potential infectious disease outbreaks, coordinate with state, regional and local entities to store, distribute (including mass vaccination clinics) and track vaccines, anti-virals and to report adverse reactions to vaccines.

By the end of the budget period local, regional and state plans will be in final draft form and ready to be initially tested through table-top exercises. In the following year, more extensive functional or full-scale exercises will be carried out.

---

[*] CDC – HRSA Coordination

Focus Area A, Section II, Critical Capacity A, <u>Benchmarks 5 & 6</u>
Develop Local, State and Regional Plans to Respond to Bioterrorism

Benchmark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
Area A, Section II, Benchmarks 5 & 6	Develop local, state-wide and regional plans to respond to bioterrorism and other emergencies	Recruit and hire (or identify) planners/ emergency coordinators	LHJs	Planning staff is hired or planning responsibility assigned to existing staff	5/02
		Develop guidance for plan completion Train planners and local emergency preparedness coordinators on plan development and assessment findings	LHJs, hospitals,[*] EMD	Planning guidance and training complete;	7/02
		Begin development or revision/updating of local health jurisdiction and hospital plans using data from capacity and needs assessments	LHJs, hospitals,[*] EMAs	Regional and field staff confirm progress	8/02
		Local plan development continues with technical assistance from state and regional planners Begin development of regional response plans	LHJs, hospitals,[*] EMAs	Regional and field staff confirm progress	9/02
		Update ESF-8 to state CEMP	State agencies, EMD	Updated ESF-8 Annex submitted to EMD	10/02

---

[*] CDC – HRSA Coordination

Benchmark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		Complete initial drafts of LHJ and hospital plans

Begin development of state-wide bioterrorism response plan | LHJs, hospitals,[*] EMAs, State agencies, EMD | Regional and field staff confirm progress | 12/02 |
		Conduct Tabletop Exercises of local Response Plans	Local public safety agencies,[*] hospitals,[*] and other community partners	Exercises completed	3/03
		Revise local plans based on lessons learned from tabletop exercises	Local public safety agencies,[*] hospitals,[*] and other community partners	Plans updated, regional and field staff confirm progress	4/03
		Participate in TopOff Full-scale Exercise (tentative)	Federal, state, regional, local, players, including hospitals[*]	Exercise completed, lessons identified	5/03
		Complete initial drafts of Regional Response Plans, incorporating provisions of capacity assessments, local plans, and lessons learned from tabletop exercises	LHJs, other local, state, and federal agencies; hospitals[*]	Initial drafts completed	6/03
		Complete final drafts of Regional plans

Complete initial draft of Statewide Response Plan | LHJs, other local, state, and federal agencies; hospitals[*] | Regional plans finalized; statewide plan drafted | 8/03 |

---

[*] CDC – HRSA Coordination

Critical Capacity B

Ensure that state, local, and regional preparedness for and response to bioterrorism, infectious disease outbreaks, and other public health threats and emergencies are effectively coordinated with federal response assets.

Existing Capacity

The state has substantial capacity in this area. For many years the state and a limited number of directly-affected local jurisdictions have had plans and conducted exercises with federal agencies for special hazards, primarily at the U.S. Department of Energy's Hanford Reservation and at the U.S. Army's chemical weapons storage depot immediately across the Columbia River from Washington's Benton County at Umatilla, Oregon.

Additionally, the state (with considerable assistance from local government partners) has been developing a plan to receive and manage the National Pharmaceutical Stockpile since January 2001. The plan has been shared with more than twenty states. The concept was briefed at the April 2001 national meeting of the Metropolitan Medical Response System. A drill of the plan was scheduled in September 2001 at the fall national MMRS Conference. It was postponed due to the terrorist attacks In New York City. In January 2002 a full drill of the dispensing (chemoprophylaxis) portion of the plan was conducted. Consistent with the state's philosophy, the NPS plan, when finalized, is to be a separately-published part of our state's Comprehensive Emergency Management Plan; i.e., *ESF-8, Health and Medical Services*.

Washington has three MMRS cities. Seattle was included in the first round of funding and has developed a comprehensive MMRS plan and has assembled a significant amount of equipment to support this activity. Spokane and Tacoma first received funding in FY-02 and are now developing their MMRS capability.

One Disaster Medical Assistance Team (designated WA-1) exists within the state. While this DMAT is not sponsored by or subject to the direction or control of any local or state official, it may be available to respond to mass casualty events throughout the state.

Along with the health agencies of other states, the Washington Department of Health is a partner in a federal regional workgroup to coordinate the use of federal assets through ESF-8. The Medical Readiness, Training, and Education (MRTE) workgroup is coordinated by our HHS/OEP regional coordinator and facilitates local-state-federal planning integration.

An MRTE initiative is underway in our state to develop memoranda of agreement with some local DoD and VA medical facilities that will describe their immediate response role in a mass casualty event that may occur in our communities where significant federal medical facilities exist. Local, regional, and state plans will reflect these provisions once they are developed.

TOPOFF II. As of this writing, it appears likely that Washington will be one of two states hosting the 2003 Top Officials (TOPOFF) exercise program sponsored jointly by the Departments of Justice and State. TOPOFF includes a series of seminars and exercises, culminating in a lengthy full-scale exercise in May 2003. We do not yet know what scenario (hazard) TOPOFF will feature in our state. TOPOFF will likely have a significant impact on the

state and affected local jurisdictions (at least Seattle and King County, but likely others as well) during the performance period.

Determination of Adequacy

This current capacity, while substantial, is still inadequate. Preparations for the NPS have been focused at the state level. Local jurisdictions have, in most cases, developed no plans for receiving and dispensing elements of the NPS. The state NPS plan does not adequately address vaccine distribution, nor does it adequately identify all the persons to be trained to carry out the functions of our NPS plan. Agreements and plans for immediate use of locally situated federal assets do not exist.

Proposed improvements: Provide funding and technical assistance to local jurisdictions to develop local plans to receive, distribute, and dispense elements of the NPS. This includes identification of those to be trained to carry out the plan—at the local and state levels. In all cases, such plans must be part of or consistent with local comprehensive emergency management plans and the overall state and (eventually) regional emergency management plans. Naturally, the request, receipt, and distribution of the NPS will be featured in exercises conducted under this grant.

A primary responsibility for staff funded under this focus area is the assurance that plans at all levels are consistent with existing planning structures. This shall include the emergency support function concept that exists in the Federal Response Plan and the state Comprehensive Emergency Management Plan as well as hospitals, and the MMRS and NDMS systems.

If, as appears likely, Washington hosts TOPOFF II, health agencies will participate. Until we know more about the scenario, the extent of that participation cannot be stated.

Washington and its affected jurisdictions will continue to participate in the preparedness (i.e., planning and exercising) efforts of federal partners. The state will continue work begun this year to conclude agreements with DoD and VA hospitals to use those resources when needed and available.

Benchmark #7: Interim Plan to Receive and Manage NPS Items

The state of Washington has more than an interim plan in place. A draft of the comprehensive NPS plan is close to completion. Per verbal guidance received in the March 21, 2003 conference call, the plan itself (over 100 pages) is not included in this work plan The plan covers decision-making, receipt, repackaging, distribution, dispensing, return, training and exercising. The plan is divided into sections (tabs), which are individual stand-alone guidelines for a particular function of the Washington NPS plan. The draft tabs are in various stages of development and are organized as follows:

- **Tab A Roles and Responsibilities:** This tab assigns specific roles and responsibilities to federal and state agencies.
- **Tab B Decision Making Process:** This section provides guidelines used in determining if and when the Governor or one of the designees should request deployment of the NPS.
- **Tab C Preparing to Receive**: This section provides specific duties to members of the DOH, LHJ, L&I, CDC, as well as the local airport authorities and local police departments. (This tab outlines the specifics regarding facilities, personnel, and equipment required to receive the NPS push packages).
- **Tab D Managing**: This portion is under the direct control of DOH. However, it is at this step in the process that the LHJs become fully involved. The LHJ is to be responsible for assisting the state as needed with staff to expedite the repackaging and distribution of bulk supplies for delivery to LHJ dispensing sites.
- **Tab E Dispensing**: The lead for the Dispensing portion would be the LHJ in the affected area. The guidelines within the plan are intended to assist the LHJ setup a dispensing clinic and dispense the medications needed by potentially exposed persons, again with DOH assistance as requested by the LHJ. In order to dispense medications, a large number of qualified pharmacists and pharmacy assistants would are utilized, as well as other medical professionals and volunteers.

The most critical portion of this plan (dispensing tab) was tested in a January exercise at the University of Washington. CDC (Adcock) observed this drill and debriefed the state planning committee. Lessons learned from the event will be reflected in the next version of the plan. CDC NPS program has informed the state that this plan was the first state plan to be evaluated using the CDC plan evaluation instrument. While indicating that Washington's plan is satisfactory, CDC NPS program staff did provide some recommendations which have been incorporated in plan updates. The plan now contains a section addressing training and exercises, including identification of staff to be trained.

Under the state's NPS plan, the state Department of Health will receive the stockpile, repackage as necessary, and distribute its elements to the local health jurisdiction(s) and hospitals affected by the emergency event. These activities will be coordinated and monitored from the state EOC. State and local agencies (e.g., law enforcement and transportation) will assist as required. The state NPS plans contains a dispensing "template" that LHJs can use on an interim basis. Local health jurisdictions will receive funding through this grant to fully develop plans to dispense NPS elements to affected persons. This template was developed by Public Health Seattle-King County with considerable input from the state NPS planning committee.

Focus Area A, Section II, Critical Capacity B, Benchmark 7
Develop a plan to Receive and Manage Items from the National Pharmaceutical Stockpile

Benchmark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
7	Interim NPS Plan	Finalize state NPS Plan Begin Development of LHJ NPS plans	LHJs, Pharmacies, EMD	Draft plan is completed, personnel are identified to be trained	7/02
7	Interim NPS Plan	Begin Development of Regional NPS support plans	LHJs, Pharmacies, EMD		
	Participate in exercises conducted by federal agencies	TOPOFF II	DOJ, FEMA, EMD, local jurisdictions	Health agencies participate in TopOff 2 as scenario warrants, gathering lessons learned	5/03
7	Interim NPS Plan	Complete draft NPS plan at local and regional levels	LHJs, Pharmacies, EMD	Draft plan is completed, personnel are identified to be trained	8/03

Section III: National Pharmaceutical Stockpile Preparedness
Critical Capacity A

Effectively manage the CDC National Pharmaceutical Stockpile (NPS), should it be deployed—translating NPS plans into firm preparations, periodic testing of NPS preparedness, and periodic training for entities and individuals that are part of NPS preparedness.

Existing Capacity

As described in Section II, Washington has significant capacity at the state level. Our plan is nearly complete and was the first to be evaluated by CDC NPS staff using their new assessment instrument. The plan's dispensing tab was tested in January 2002. Shortcomings found have been addressed in subsequent revisions. The plan has become part of the state's Comprehensive Emergency Management Plan as an appendix under Emergency Support Function 8, *Health and Medical Services* (ESF 8).

Adequacy of Existing Capacity

The existing capacity is inadequate because local plans have yet to be fully developed. Also, the state plan has not been fully tested. It also needs to add provisions for vaccine distribution. The state has not identified and trained all the persons it will need to implement its plan.

Proposed Improvements

As described in Section II, provide funds and technical assistance to local jurisdictions to develop and test NPS plans.

Complete the final state NPS plan, including provisions for vaccine distribution. Train state, local, and selected hospital staff. Document commitments from all relevant entities charged with carrying out plan provisions. Bring NPS plans into full compliance with CDC NPS guidance documents.

Test state NPS plan through a functional exercise and/or field drill involving one or more LHJ. Incorporate NPS in all LHJ tabletop exercises conducted as described in Part II of this work plan.

Section III, Critical Capacity A, National Pharmaceutical Stockpile Preparedness

Workplan Timeline

Capacity	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
Activities A	Test state existing state NPS Plan	Functional Exercise	LHJs, Pharmacies, EMD, Hospitals[*]	State NPS plan is tested through an exercise; lessons learned are incorporated into plan revisions	7/03
A	Test local NPS plans developed under Section II, Critical Capacity B	Tabletop Exercise	Pharmacies, EMD, Hospitals[*]	NPS plan is tested through an exercise; lessons learned are incorporated into plan revisions	8/03

---

[*] CDC – HRSA Coordination

Budget Narrative
(Consolidates all Critical Capacities in Focus Area A)

Personnel ....**$ 1,053,538**

      1 Special Assistant (Executive) $77,004/year X 1.25 FTE = $96,255
      1 Emergency Program Manager (WMS Band 2) $64,776 X 1.25 = $80,970
      1 Assessment Manager (Temp – 8 mos) $60,180 X 0.67 = $40,122
      2 State Planners (Health Services Consultant 3) $53,136 X 2.5 =$132,840
      4 Divisional Coordinators (HSC 3 – 12 mos) $53,136 X 4 = $212,544
      4 Field Technical Advisors (HSC 3 – 15 mos) $53,136 X 5 = $265,680
      1 Secretary Admin for Emergency Program Manager $28,200 X 1.25 = $35,250
      1 DOH Rules/legal assessment (other than AG's Office) $25,000
      State Board of Health staff time $21,000
      Pre-application planning activities (up to 40 staff averaging 12 FTEs per week
      for10 weeks (on time sheets) $138,877
      State Board of Health Pre-application planning activities $ 5,000

Fringe Benefits ....**$ 252,849**

      Calculated at DOH rate of 24% of salary.

Travel ....**$ 61,500**

      Includes estimated per diem, mileage, and air fare expenses for Special Assistant,
      Emergency Program Manager, Assessment Staff, Planners, Field Technical Advisors,
      Committees, and State Board of Health. Includes vehicle lease & fuel estimates (1
      vehicle per Field Advisor and 1 for Emergency Program Management)

Supplies ....**$ 25,075**

      Standard office supplies for the 15.5 DOH positions@ $650 = $10,075
      Supplies for committee support = $ 15,000

Contract over $25,000**….…………………………………..………..**$ 3,452,155

      Pass-thru to lead county in regions for assessments, planning, and exercises = $2,400,000
      Pass-thru to other counties for assessments, planning, and exercises = $1,025,000
      Immunizations assessment $27,155

CDC Public Health Preparedness and Response for Bioterrorism Resource Management

Lead and Counties	A LHJ Planning	A Regional Planning	B EPI/ Surveillance	C Lab	E HAN	F Communication/ Public Information	G Training/ Education	TOTAL
Bremerton-Kitsap	$75,000	$100,000	$230,000		$8,000		$135,000	$548,000
Clallam	50,000				15,000			65,000
Jefferson	25,000							25,000
Thurston	75,000	100,000	235,000		8,000		135,000	553,000
Lewis	50,000				15,000			65,000
Pacific	25,000							25,000
Grays Harbor	50,000				15,000			65,000
Mason	50,000							50,000
Southwest	125,000	100,000	235,000		8,000		135,000	603,000
Cowlitz	50,000		55,000		15,000			120,000
Wahkiakum	25,000							25,000
Pierce	325,000		355,000		8,000		135,000	823,000
King	550,000		682,500	100,000	8,000	83,500	135,000	1,559,000
Snohomish	150,000	100,000	365,000		8,000		135,000	758,000
Skagit	75,000		55,000					130,000
Whatcom	75,000		55,000					130,000
Island	50,000				15,000			65,000
San Juan	25,000							25,000
Chelan-Douglas	75,000	100,000	227,000		38,000*		135,000	575,000
Okanogan	25,000							25,000
Grant	50,000				15,000			65,000
Kittitas	25,000							25,000
Benton-Franklin	125,000	100,000	350,000		8,000		135,000	718,000
Walla Walla	50,000							50,000
Yakima	75,000							75,000
Klickitat	25,000							25,000
Spokane – North	100,000	100,000	240,000	167,500	8,000	83,500	135,000	834,000
NE Tri	75,000				15,000¥			90,000
Lincoln	25,000							25,000
Spokane – South		100,000	113,000		8,000		135,000	356,000
Whitman	25,000		55,000		15,000			95,000
Garfield	25,000							25,000
Columbia	25,000							25,000
Adams	25,000							25,000
Asotin	25,000							25,000
Total $	2,625,000	800,000	3,252,500	267,500	230,000	167,000	1,350,000	$8,692,000

*15,000 Douglas

¥15,000 Stevens

Other .... **$ 182,140**

- ▪ Equipment (less than $5,000 individual)
    - • 4 Laptop Computers for Field Advisors @ $2,500 = $10,000
    - • 15 Complete Workstations including furnishings and computers
        @ $8,500 = $127,500
- ▪ Telephone: $100/month x 15 = $1,500 X 15.5 = $23,250
- ▪ Information Services charge-back (for networks, software support, etc): 1,104/year X
    1.25 yrs X 15.5 FTE = $21,390

Indirect ....**$ 376,923**
21.3 % applied to non-contract costs = $335,823
1.2% applied to contracts over $ 20,000 = $ 41,100

Total Assistance Requested..**$5,404,180**

Focus Area B, Section I, Epidemiology and Surveillance

Critical Capacity A

To rapidly detect a terrorist event through a highly functioning, mandatory reportable disease surveillance system, as evidenced by ongoing timely and complete reporting by providers and laboratories in a jurisdiction, especially of illnesses and conditions possibly resulting from bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

Existing Capacity

In Washington State, communicable disease surveillance and outbreak investigation are mandated for selected notifiable diseases of public health importance under Washington Administrative Code (WAC) 246-101; this code was recently modified to include reporting of disease due to agents of potential bioterrorism and unexplained critical illness and death. Both suspected and confirmed cases are notifiable. Local health officers or the state Health Officer can require reporting of additional conditions on a routine or emergency basis under the authority of the WAC. Health care providers, laboratories, health care facilities, food service establishments, child day care facilities, and schools are required to report notifiable conditions to 34 local health jurisdictions (LHJs) or the Washington State Department of Health (DOH) by county of residence of the case. In addition, the WAC also requires veterinarians to report selected animal diseases. Immediate reporting by telephone or fax is required for outbreaks or specified conditions of major public health significance such as agents potentially associated with bioterrorism. All LHJs have designated staff for 24-hour emergency telephone contact (data collected and distributed to all LHJs and designated DOH staff in the DOH "Red Book") but not necessarily for receipt of disease reports. DOH Communicable Disease Epidemiology (CDE) maintains 24-hour on call coverage by a medical epidemiologist to receive reports directly from disease reporters if the LHJ is unavailable. Routine reporting from LHJ to DOH is by telephone, mail, fax or in a few cases, secure electronic transmission. Currently LHJs must submit case reports and outbreak reports to DOH within seven days of completion, or within 21 days of the report to the LHJ.

Determination of Adequacy

The Washington State 2000 Public Health Emergency Preparedness Assessment (PHEPA) found that only 11 LHJs employed at least one full-time epidemiologist per jurisdiction. Additionally, in many cases this epidemiologist's scope of work did not include communicable diseases. Many LHJs did not have full-time communicable disease surveillance staff, rather disease surveillance composed only a very small part of their responsibilities. Thus, most LHJs do not have staff time available for developing relationships with health care providers to increase disease reporting. Another finding of the PHEPA was the lack of daily monitoring by LHJs of key health indicators such as emergency department utilization or 911 calls.

As a part of the development of Standards for Public Health in Washington, a program to measure performance of public health agencies, a preliminary test of compliance with the proposed standards was conducted in all LHJs in the summer of 2000. The results in the area of communicable disease provide the basis for our understanding of LHJ capacity:

- 40% did not fully comply with the standard requiring maintenance of a surveillance system to identify emerging health threats

- 41% did not fully comply with a standard of maintaining written protocols for receiving and reporting notifiable conditions
- 31% did not fully comply with the standard requiring a system for having a reporting system that was available 24 hours a day, or an available phone number for reporting public health emergencies

The state Attorney General's Office recently conducted an assessment of Washington State's public health legal authorities. The AAG provided the opinion that local health officers have broad authorities including the authority to require and receive reports on and to investigate any suspect notifiable condition, potential bioterrorist events, or unusual illness cluster.

There is significant variability among the LHJs regarding the attributes of their communicable disease surveillance systems, methods used to promote reporting by health care providers and laboratories, and format and frequency of the distribution of analyzed and interpreted data to those who report notifiable conditions. A systematic assessment of the completeness of communicable disease surveillance has not been conducted for all LHJs. It is not known to what extent health care providers across the state are familiar with the recently revised reporting requirements for diseases compatible with bioterrorism. Results of interviews of six LHJs in 1999 regarding notifiable conditions reporting indicated that LHJs believed most providers are not familiar with disease reporting requirements, while most local laboratories do comply with these requirements.

Proposal for Effecting Improvements

- Enhance communicable disease personnel to improve the surveillance for notifiable conditions at the state, regional and local levels.
- Develop a system to receive and evaluate urgent disease reports from all disease reporters and LHJs on a 24 hours a day, 7 days a week basis and train appropriate staff. (See Critical Benchmark #8)
- Conduct an initial assessment by applying a standardized surveillance system evaluation tool to each LHJ in order to identify best practices, with a method for focusing improvements based on the results
- Develop continuum of enhanced surveillance activities which may be utilized as appropriate on a local or regional basis
- Develop a standard protocol to regularly assess LHJ surveillance activities for timeliness and completeness to improve the utility of the reportable disease system
- Provide regular training to public health staff on disease reporting and surveillance in a variety of formats, including a regional program for practical training

Adding staffing, equipment and technologies as appropriate will extend communicable disease surveillance system capacity. An epidemiologist or experienced disease surveillance and investigation staff person will be hired or identified to coordinate surveillance and epidemiology activities in each region and at DOH. Once identified, these Regional Coordinators will attend standardized training coordinated by DOH. Linking with Focus Area C,[*] a molecular epidemiologist will also be added to enhance our ability to develop rapid detection methods and to assist in the understanding of laboratory diagnostic methods. The Regional Epidemiology

---

[*] Focus Area Integration

71

Coordinators will work with the identified lead LHJ in each public health region and will assist each LHJ in their region in developing their critical capacity for early detection as evidenced by a timely and complete surveillance system. The Regional Epidemiology Coordinators will provide epidemiology support through mutual aid agreements to LHJs in their region and between regions on request. DOH will have a lead Epidemiology Coordinator who will work with the regional coordinators to provide guidance and training and to develop best practices in order to ensure progress towards capacity is being made in each public health region.

This proposal plans to assure that each LHJ can receive and evaluate disease reports of critical public health importance, 24 hours a day, either directly or through DOH using the Public Health Issues Management System (PHIMS). This technology, which is currently under development, will provide a secure, confidential mechanism for local health agencies and health care providers to provide disease surveillance data through a web-based system (See attached Critical Benchmark #8). This system will include an integrated data repository that allows users access to report forms for notifiable conditions, including those for diseases due to potential bioterrorism agents and unexplained critical illness or death. Access to the system will occur through secure means, and privileges for using PHIMS will be authorized based on a protocol that grants users appropriate access according to their public health role.

In order to fully understand epidemiologic capacity gaps in Washington, a comprehensive assessment will be developed and conducted in all LHJs. This assessment tool will use existing resources (e.g., recently revised CDC criteria for evaluation of surveillance systems) in addition to novel questions, and will have methods for communicating the findings and focusing improvements based on identified gaps. This assessment will evaluate surveillance system attributes that are readily ascertainable and focus on immediately notifiable diseases of public health importance. Focus will be placed on staffing capacity, health care system structure, best practices, and training needs for public health and community reporting staff.

With the information from the comprehensive assessment, a workgroup consisting of local, regional, and state epidemiology staff will develop a standard protocol to regularly assess LHJ surveillance activities. This protocol will include criteria for assessing reporting efficiency by evaluating the timing of report receipt and delivery at consecutive steps in the reporting process (e.g. first notification, investigation initiation, case contact, etc). This protocol will be applied for notifiable conditions having critical public health importance, such as invasive bacterial diseases, vaccine preventable diseases, vector-borne diseases and food- and waterborne diseases. The results of periodic local or regional assessments will be shared with appropriate public health agencies, and used to focus efforts for improvements on an ongoing basis.

Linking with Focus Area G,[*] training needs for notifiable condition reporters (e.g., health care providers, laboratorians, and veterinarians) identified in the original and ongoing assessments will be addressed through existing and innovative programs, such as medical grand rounds and other relevant clinical training, and epidemiology and surveillance trainings offered by local, state, academic and federal partners. Critical topics for presentation will include public health surveillance and notifiable condition reporting, basic epidemiology, and recently revised reporting requirements, such as those for unexplained critical illness or death. Opportunities to provide continuing education credit will be utilized to make educational programs attractive to health care providers. We will strive to collaborate with educational initiatives in Focus Areas C

and F[*] that focus on health care and provider associations, hospitals and clinical laboratories to ensure that key disease reporters (emergency health care providers, infection control practitioners, infectious disease physicians, and laboratories) are targeted. Updated local or regional lists of health care providers, agencies, clinical laboratories and non-traditional reporters (e.g., veterinarians, pharmacists, homeopathic practitioners, medical examiners and coroners) will be maintained in order to communicate training opportunities through websites, regular newsletters, and electronic list serves. Targeted outreach will occur on a local or regional level, utilizing liaisons or other staff, to ensure that health care providers and laboratories are aware of the requirements and capacity for notifiable condition reporting, including after-hours access to reporting by telephone.

Working with Focus Area G,[*] all public health regions will have distance learning capacity and the ability to develop methods for publicizing relevant training opportunities to the appropriate target audiences. Regional Epidemiology Coordinators will work with disease surveillance staff in LHJs to continuously identify training needs and coordinate with Focus Area G[*] to address these needs. In collaboration with efforts in Focus Area G, [*] a regional program will be developed to provide practical training in epidemiology and surveillance that will allow public health staff throughout the state to train with highly skilled disease investigators and epidemiologists. Selected public health staff would be trained through a standardized program adapted from the Epidemiology in Action Program, and in a "train-the-trainer" model, share their expertise with others in their region. The DOH Epidemiology Coordinator will work with LHJ communicable disease staff to determine their needs for conducting analysis of surveillance data and to provide training on the appropriate analytic methods (i.e., EpiQMS, Vista, EpiInfo, GIS).

Regional Epidemiology Coordinators will develop protocols for enhanced surveillance including active surveillance and syndromic surveillance, which can be utilized by local or regional public health systems as appropriate. The protocols for enhanced surveillance will focus on monitoring of key health indicators such as emergency department utilization, 911 calls or poison control center calls. Regions will select enhanced surveillance systems to develop and share lessons learned with other regions. For example, a febrile rash illness surveillance system will be developed and deployed on a regional or local basis throughout the state. This plan will include mechanisms to actively educate public health, primary care providers, hospitals and emergency department personnel,[†] and others of the differential diagnoses of febrile rash illnesses including smallpox and varicella, as well as the need and methods for immediate reporting to prevent or contain outbreaks. Linking with Focus Area C,[*] the plan will include the development of a protocol for collection, transport and testing of clinical specimens from suspected smallpox cases, including the ability to rapidly rule out varicella infection. This protocol would be tailored to each region since availability and accessibility of resources is not consistent throughout the state.

---

[*] Focus Area Integration
[†] CDC – HRSA Coordination

Focus Area B, Section I, Critical Capacity A
Detection of Bioterrorism or Infectious Disease Events Through a Disease Surveillance System
Work Plan Timeline

Capacity #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
Activities: BCCA	Improve epidemiologic capacity to manage the reportable disease system	Hire a minimum of 1 disease surveillance staff to coordinate surveillance and epidemiology activities in each region and at DOH	LHJ	Regional and DOH Epidemiology Coordinators hired	7/30/02
BCCA LINK E	Improve surveillance and epidemiologic capacity at LHJ	Develop a work plan for Regional Epi Coordinators with priority activities and timelines	LHJ	Work plan produced and distributed to Regional Epi Coordinators	8/30/02
BCCA/ Bench-mark #8	Develop and enhance information technology for disease surveillance	Deploy information technology including PHIMS, to receive urgent disease reports from all parts of the state 24/7, and train appropriate staff	LHJ, HCPs/ Facilities, labs	PHIMS 1.0 deployed to all LHJs and staff is trained for use PHIMS 2.0 deployed to selected HCPs	12/31/02 8/30/02
BCCA	Improve timeliness and completeness of surveillance system	Develop and apply a standardized surveillance system evaluation tool Apply evaluation tool at least yearly	LHJ	Evaluation tool workgroup established System evaluation conducted Improvement plan developed	8/30/02 10/30/02 11/30/02
BCCA LINK HRSA	Improve ability to detect unusual disease occurrences	Develop continuum of enhanced surveillance activities which may be utilized as appropriate on a local or regional basis	LHJ, HCPs/ Facilities, labs	Protocols developed for monitoring key health indicators such as emergency department visits,[*] 911 calls or febrile rash illness	8/30/03
BCCA LINK G	Improve public health staff competency to manage the reportable conditions system	Assess training and resources needed; Identify or create content for training	LHJ	Provide regular training to public health staff in a variety of formats	4/30/03
BCCA	Improve key reporters understanding of notifiable conditions reporting system	Generate list of key reporters in each LHJ/region; Develop plan to regularly disseminate information about current activities and training	LHJ, HCPs/ Facilities, labs	Develop local list serve; Regularly publish regional/local newsletter	1/30/03 2/30/03
BCCA	Improve reporting of notifiable conditions	Develop a system to provide targeted outreach to key reporters	LHJ, HCPs/ Facilities, labs	System to provide targeted outreach developed	2/30/03

---

[*] CDC – HRSA Coordination

Focus Area B, Section I, Critical Capacity A, <u>Benchmark 8</u>

Prepare a timeline for developing a system to receive and evaluate urgent disease reports from all parts of your state and local public health jurisdictions on a 24-hour per day, 7-day per week basis.

As described in Focus Area B, Critical Capacity A, the Washington Administrative Code requires reporting of disease by health care providers, laboratories, and other agencies, with immediate notification for outbreaks or conditions of major public health significance, including diseases potentially associated with bioterrorism. Washington State Department of Health Communicable Disease Epidemiology maintains 24 hour on call coverage by a medical epidemiologist to receive reports directly from disease reporters if a LHJ cannot be reached after regular working hours.

In order to improve our ability to receive and evaluate reports of conditions having urgent public health implications, Washington State has designed and is developing PHIMS (Public Health Issue Management System), a secure, electronic disease surveillance system that will allow LHJs to investigate and electronically report cases of notifiable conditions to the state. In conjunction with the development of PHIMS, the Disease Condition Database (DCD), a state repository for notifiable conditions data, is also being developed. When a case captured in PHIMS meets reporting requirements (WAC 246-101), the required data will be automatically updated in DCD. DCD will also be the state repository for notifiable conditions not reported through PHIMS (e.g. birth defects, pesticide poisoning, blood-lead levels).

PHIMS Version 1.0 will allow LHJs to capture data from case investigations including: demographics, reporting source, risk factors and exposures, contacts, and clinical information, including laboratory results and treatment. The system can then be used to report cases to DOH electronically, 24 hours a day, 7 days a week. PHIMS has been designed in partnership with the local health agencies of Washington State, from inception through all phases of system development. PHIMS architecture and design standards have been developed according to NEDSS standards and in compliance with the NEDSS Base system and the Public Health Conceptual Data Model.

PHIMS Version 2.0 will add conditions not included in Version 1.0 (e.g., tuberculosis and vaccine adverse events reporting), will allow linking of data for the investigation of food- and waterborne outbreaks, and will modify the PHIMS application and database to be patient-based, rather than disease- or condition-based. This final modification will allow better analysis of longitudinal data related to certain notifiable conditions such as sexually transmitted diseases. Version 2.0 will also include a web entry screen for use by health care providers to allow reporting directly via PHIMS. This version will include integration with the laboratory reporting systems as proposed in Focus Area E,[*] as well as integration with the alert and notification features of the Health Alert Network (HAN).

DCD Version 1.0 will be implemented in conjunction with PHIMS Version 1.0. It will include an automated reporting interface from PHIMS (PHIMS-DCD Integration Implementation) and a

---

[*] Focus Area Integration

quality assurance interface to ensure state and national case definition criteria are met for each reported case. As the state repository for notifiable conditions data, DCD will be a source for epidemiological assessment. Included in the implementation of DCD will be conversion of data from existing systems and development of a standard CDC interface for reporting nationally notifiable conditions.

Ultimately, it is envisioned that PHIMS-HAN Integration will utilize information recorded in PHIMS to automatically alert designated persons at LHJs and DOH whenever a case or outbreak of interest (i.e. critical agent) is reported. Once data regarding the situation is confirmed, the public health emergency response system would then be alerted via e-mail, broadcast faxes, pagers, and automatically dialed voice mail messages (see description of WA-SECURES, Focus Area E, Critical Capacity A.[*])

---

[*] Focus Area Integration

Focus Area B, Section I, Critical Capacity A, <u>Benchmark #8</u>
Receive and Evaluate Urgent Disease Reports

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
BCCA/#8	Web-Based Data Entry and BT and Communicable Disease Investigation Application	Finish Construction of PHIMS 1.0	Pilot LHJs, PHIMS and DCD Contractors	Completion of initial development and implementation in three pilot LHJs	7-02
BCCA/#8	Web-Based Data Entry and BT and Communicable Disease Investigation Application	Implementation of PHIMS 1.0 across Washington's LHJs	LHJs	Deployment in 90% of LHJs	12-02
BCCA/#8	State Level Integrated Data Repository	Establishment of Technical Environment for DCD 1.0, Migration of Legacy Data Sets, Implement QA Interface	DOH	Deployment in Production Environment	12-02
BCCA/#8	Improve Web-Based Data Entry System and Integrated Data Repository to meet NLDM Extension of HL7 RIM	Design and Construction of PHIMS 2.0 and DCD 2.0	LHJs, HCPs	Deployment to DOH and all LHJs Deployment to selected infectious disease practitioners	8-03

Focus Area B, Section II, Epidemiology and Surveillance

Critical Capacity A

Rapidly and effectively investigate and respond to a potential terrorist event as evidenced by a comprehensive and exercised epidemiologic response plan that addresses surge capacity, delivery of mass prophylaxis and immunizations, and pre-event development of specific epidemiologic investigation and response needs.

Existing Capacity

As part of Washington's current Bioterrorism Preparedness and Response Cooperative Agreement, a Bioterrorism Team (includes DOH Bioterrorism Surveillance and Response Coordinator, local Bioterrorism Coordinators, the Health Alert Network Coordinator, and the DOH Emergency Manager) has been working diligently to coordinate planning within our agencies and with emergency response partners. The Bioterrorism Team is actively developing components of an epidemiologic response plan, which includes levels of notification and response based on identified epidemiologic triggers. In collaboration with two local health jurisdictions (LHJs) funded through the original cooperative agreement, local protocols for evaluation and investigation of suspicious illnesses potentially compatible with biological terrorism have been drafted. A standardized data collection instrument for unexplained illness or death has also been developed.

DOH, with LHJs and other local, state and federal partners, has been developing a plan to receive, breakdown, distribute and dispense elements of the National Pharmaceutical Stockpile (NPS) since January 2001. The draft plan has been shared with more than twenty states and CDC. In January 2002, a full drill of the dispensing portion of the plan was conducted, using chemoprophylaxis for anthrax as the model. Consistent with the state's philosophy, the NPS plan, when finalized, is to be part of the state's Comprehensive Emergency Management Plan (i.e., *ESF-8, Health and Medical Services*).

Based on lessons learned from the dispensing drill, a revision is in process. Following this revision the mass dispensing plan will be shared with LHJs and Public Health Regions throughout the State. The plan will be useful in the context of expected, naturally occurring disease outbreaks requiring mass post-exposure prophylaxis (e.g., hepatitis A, meningococcal disease) as well as for dispensing of the NPS components.

Through the current CDC Bioterrorism Cooperative Agreement, DOH developed a bioterrorism tabletop exercise entitled "*Hands On Training for Public Health Emergencies.*" This exercise is designed to facilitate interaction between local public health, hospitals,[*] local emergency management agencies and others who would respond in a public health emergency. The Bioterrorism Team is in the process of facilitating this exercise in each county in Washington and in some neighboring counties in Idaho.

---

[*] CDC – HRSA Coordination

Determination of Adequacy

Although several LHJs have experience investigating and responding to large outbreaks and have emergency disaster response protocols, there is not a formal, standardized Epidemiologic Response Plan in use throughout the state. A need exists to further develop notification and response triggers and to incorporate this data into a statewide Epidemiologic Response Plan. In addition, this plan needs to include the ability to identify surge capacity through mutual aid agreements between regions and LHJs (See Focus Area A, Critical Capacity B, Benchmark #4[*]). The capacity to adequately address communicable disease surveillance is insufficient in LHJs across the state, let alone to develop plans or provide needed training.

Preparations for the NPS have been focused at the state level with attention given to development of local templates for dispensing mass chemoprophylaxis. Local health jurisdictions have not operationalized templates into county or region specific plans for receiving and dispensing elements of the NPS. The state NPS plan does not adequately address vaccine distribution, nor does it adequately identify personnel to be trained to carry out the functions of our NPS plan. Additionally a training component of NPS plan for state or local components has not been fully developed.

Proposed Improvements

- Assess current level of epidemiologic expertise in each LHJ (See Benchmark #9)
- Add appropriate epidemiologic expertise to LHJs or Public Health Region as identified by needs assessment (See Benchmark #9)
- Develop statewide Epidemiologic Response Plan in conjunction with Focus Area A[*] and HRSA-funded Hospital Planning group[†]
- Develop mutual aid agreements for epidemiologic response capacity between and within the Public Health Regions
- Develop and provide training to public health staff on Epidemiologic Response Plan
- Develop rapid, secure information dissemination mechanisms
- Continue to develop audience specific bioterrorism information and provide presentations to key disease reporters and agencies
- Develop and provide tabletop and functional exercises to test the Epidemiologic Response Plan

A rapid standardized assessment tool, integrated between appropriate focus areas, will be developed and administered by Focus Area A[*] Regional Coordinators and will include an initial assessment of epidemiologic capacity in each LHJ. In order to effect improvements in this capacity, this proposal describes a model where each public health region will designate an Epidemiology Response Coordinator. This coordinator will work with the LHJs in their regions and the other regional coordinators to develop criteria for standardized response protocols and establish surge capacity that will provide the basis for a statewide Epidemiologic Response Plan. In addition, these coordinators will work to integrate epidemiologic investigation and response planning with other regional and state emergency response plans. (See Benchmark #9)

The regional Epidemiology Response Coordinators will be responsible for developing a rapid assessment tool for assessing current epidemiology and response (including surge) capacity in

---

[*] Focus Area Integration
[†] CDC – HRSA Coordination

each region, determining the best practices currently in place throughout the state, and developing and implementing plans to ensure optimal response capacity in each region. One key component of regional and statewide response will include developing formal mutual aid agreements that would allow rapid deployment of surveillance and response staff to regions where additional resources are needed to respond to a potential or confirmed disease outbreak.

State and Regional Response Coordinators will use the current version of the CDC Interim Smallpox Response Plan as a template for developing the capacity for enhanced epidemiologic and disease investigation capacity in each of the regions, including identification and activation of surge capacity staff, case investigation, contact tracing, mass vaccine or antiviral administration and associated monitoring for adverse effects.

Regional Response Coordinators, in collaboration with regional Preparedness Coordinators (in collaboration with Focus Area A efforts[*]) and HRSA-funded hospital preparedness staff,[†] will work with health care providers, infection control practitioners and hospitals to ensure a robust and coordinated approach to critical cross-cutting response activities including enhanced surveillance and reporting, mass treatment, information management and communication. An initial assessment of this capacity will be developed, piloted, administered and analyzed.

Regional Response Coordinators will work with regional Preparedness Coordinators and local emergency managers to incorporate NPS receipt and chemoprophylaxis dispensing plans into local comprehensive emergency management plans. Local coordinators will work to identify appropriate personnel to provide training as well as possible venues for dispensing. Once the vaccine template is completed this will also be incorporated and operationalized in local jurisdictions and public health regions.

Response Coordinators will work with regional Preparedness Coordinators to develop and provide bioterrorism tabletop exercises focused on public health emergencies in order to test components of the Epidemiologic Response Plan. As components of a jurisdiction's plan are developed, more specific training will be developed and deployed. State coordinators in the various focus areas, particularly linking with Focus Area G,[*] will provide a variety of training options for regional coordinators, communicable disease staff and surge capacity staff identified to respond public health emergencies. Training content will include basic epidemiology, disease investigation, rapid needs assessment, incident command, mass immunization and drug dispensing, crisis/risk communications, triage and other areas as identified.

The state Response Coordinator will work with DOH emergency planners and regional Preparedness Coordinators to review and assess existing vulnerability assessments to determine if they are adequate for public health needs and modify them if necessary. They will also assess communication mechanisms for sharing risk and vulnerability assessments between local agencies and work with Focus Area E and F[*] to develop mechanisms where needed. Regional Response Coordinators will participate in local multi-agency bioterrorism/disaster planning groups that will include representatives from public health, public safety, emergency management, transportation, utilities, and political leadership. These regional groups will collaborate on risk assessment activities to provide an integrated local approach to bioterrorism

---

[*] Focus Area Integration
[†] CDC – HRSA Coordination

and outbreak response. State Response Coordinators will link with DOH Food Safety and Drinking Water Programs to identify existing risk and vulnerability assessments and determine if additional tools or training is needed.

Regional Coordinators will work within each region to organize necessary staff into epidemiologic response teams capable of conducting field investigations. Regional teams will provide epidemiologic assistance both within their region and throughout Washington. The size, capacity and sophistication of the regional teams will correspond to the needs of the individual regions according to the population of the region and likely risk of biological terrorism based on existing and future risk assessments.

DOH is developing the Washington State Electronic Communication Urgent Response and Exchange System (WA-SECURES), a secure web portal that provides ongoing coordination and collaboration of training materials, resources, and protocols for public health emergencies. This system will also provide a rapid and redundant call-down and alerting mechanism that is capable of contacting public health officials through many different methods in an emergency. WA-SECURES will be deployed to the public health system by Fall 2002, and in subsequent increments to hospitals, clinical laboratories,[*] emergency management agencies and public safety agencies by August 2003.

Linking with Focus Area F,[†] standardized audience-specific informational materials will continue to be developed by state and regional coordinators to facilitate the delivery of bioterrorism and communicable disease-related public health messages in the community. Informational materials will be posted and updated on existing state and local LHJ websites as well as WA-SECURES. Materials already developed by DOH and other LHJs regarding clinical, laboratory, epidemiological, and local planning aspects of bioterrorism will be standardized and made available to all regional coordinators. Lessons learned and suggested approaches to engage participation of the health care community in bioterrorism and communicable disease response planning would be made available to the regional coordinators.

State and regional Response Coordinators will develop and conduct a survey of selected health care providers including occupational health nurses, public health staff and others to identify personnel with key bioterrorism skills or who may have recently received smallpox vaccine. The State Response Coordinator will request a list of resident Washington "Smallpox Warriors" (with smallpox eradication experience) from CDC. Response Coordinators will work with the Regional Training Coordinators to identify a list of in-state experts as potential speakers on various aspects of bioterrorism and preparedness issues and will be provided to hospitals and other organizations requesting training. Sessions on bioterrorism will continue to be presented on at least an annual basis at meetings and conferences of relevant medical and veterinary groups.

---

[*] CDC – HRSA Coordination
[†] Focus Area Integration

Focus Area B, Section II, Critical Capacity A
Develop a Comprehensive and Exercised Epidemiologic Response Plan
Work Plan Timeline

Capacity/ Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
IIA/ BM9	Improve effectiveness of public health response	Add Epidemiology Response Coordinators in each region and DOH	LHJ	Epidemiology Response Coordinator hired in each region and DOH.	7/30/02
IA LINK E*	Improve epidemiologic investigation and response capacity	Develop a work plan for Regional Response Coordinators with priority activities and timelines	LHJ	Work plan produced and distributed to Regional Epi Coordinators	8/30/02
IIA LINK A*	Improve ability to investigate and respond to public health emergencies.	Develop local, regional and statewide epi response plans.	LHJ	Statewide and regional Epi Response plans developed.	6/30/03
IIA LINK A	Provide surge capacity in WA public health regions	Develop mutual aid agreements between LHJs and ensure surge capacity	LHJ	Mutual aid agreements are written and surge capacity sources are included in plans	2/30/03
IIA LINK G	Improve ability to respond to disease outbreaks.	Form regional response teams and provide cross-training	LHJ	Regional response teams identified and trained	8/30/03
IIA LINK A	Improve ability to provide mass chemoprophylaxis	Incorporate mass chemoprophylaxis dispensing template into existing plans	LHJ, HCP, EM	Local plans include dispensing component and resources have been identified to execute plan	4/30/03
IIA LINK A	Improve ability to provide mass immunizations	Adapt mass chemoprophylaxis plan for different resource needs for vaccination	LHJ, HCP	Mass Immunization template developed as part of State NPS Plan	8/30/02
IIA LINK A	Improve ability to respond to potential smallpox outbreak	Utilize CDC Interim Smallpox Response Plan to develop a template for Regions	LHJ, labs HCP/ Fac	Smallpox Annex to Epi Response Plan developed	7/30/03
IIA LINK A	Ensure understanding of roles in Epi Response Plan	Provide training to public health staff and emergency management around Epi Response Plan	LHJ, EM/ Pub Safety	Training provided to public health staff and other integral response partners	7/30/03
IIA LINK A	Test and evaluate Epi Response Plan	Develop and conduct public health emergency exercises	LHJ, EM	Conduct regional tabletop exercises of Epi Response Plan	7/30/03

---

* Focus Area Integration

Capacity/ Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
IIA LINK E, F	Provide rapid and secure information dissemination mechanism	Develop list of subscribers for WA-SECURES Develop protocol for sharing risk and vulnerability assessments	LHJ, HCP, EM/ Pub Safety	WA-SECURES Deployed to: Public Health System Hospitals[*] Public Safety	11/1/02 2/1/03 8/1/03

---

[*] CDC – HRSA Coordination

Focus Area B, Section II, Critical Capacity A, Surveillance and Epidemiology Capacity, Critical <u>Benchmark 9</u>

Assess current epidemiologic capacity and prepare a time line for achieving the goal of providing at least one epidemiologist for each Metropolitan Statistical Area (MSA) with a population greater than 500,000

Provide a brief description of how current epidemiological capacity compares to the goal.

In Washington State there are 34 local health jurisdictions (LHJs) that represent 39 counties. Washington State has three Metropolitan Statistical Areas (MSAs) with a population greater than 500,000: Seattle, Tacoma (Pierce County) and Snohomish County. The LHJs representing these MSAs each have at least one epidemiologist; however, this minimum goal does not provide the capacity that is needed in these LHJs or in other LHJs across the state to adequately address communicable disease surveillance.

The state's 2000 Public Health Emergency Preparedness Assessment (PHEPA) identified only 11 LHJs employing at least one full-time epidemiologist. In many cases this epidemiologist's scope of work did not include communicable disease. Additionally, in many LHJs, staff work in multiple program areas and disease surveillance is a very small part of what they do. Thus, most LHJ staff do not have time available for developing relationships with health care providers to increase reporting, or for developing standard protocols for disease reporting. PHEPA also identified a lack of daily monitoring by LHJs of key health indicators such as emergency department utilization, 911 calls or ambulance runs, which are potential additional sources of data to detect outbreaks.

Provide a timeline that addresses how and when the recipient will achieve the goal.

Washington's public health system proposes to address critical epidemiology and surveillance capacities utilizing a state, local, and regional approach. Ten public health regions were created to provide opportunities for local collaboration toward the critical capacities in the LHJs in their respective region. The population in these regions ranges from 85,700 to 1.7 million. A lead LHJ will coordinate regional activities; Spokane County will be the lead LHJ in two regions.

Population in Region	Number of Regions
Less than 250,000	2
250,000 to 500,000	5
500,000 to 750,000	1
750,000 to 1,000,000	1
More than 1,000,000	1

A more specific assessment of regional epidemiologic capacity is needed. Under the guidance of DOH and in conjunction with Focus Area A,[*] an initial assessment of epidemiology capacity will be conducted in all ten regions by September 2002. Following the regional needs identified in

---

[*] Focus Area Integration

this assessment the lead LHJ will provide a regional plan for addressing the needs in order to meet the critical capacities.

Funds will be provided for enhancing local and regional communicable disease staff capacity. One model to add epidemiologic capacity may designate a regional Epidemiology Coordinator to assist each LHJ in their region in assessing and developing critical capacity for early detection as evidenced by a timely and complete surveillance system (see Focus Area B, Section I). Public health regions may also designate Epidemiology Response Coordinators who will work with the other regional coordinators and the state response coordinator to develop criteria for standardized protocols and epidemiologic surge capacity that will provide the basis for a statewide Epidemiologic Response Plan (see Focus Area B, Section II). The regional coordinators will provide epidemiology support through mutual aid agreements to LHJs in their region when assistance is requested. DOH will have two lead coordinators (one for epidemiology and one for response) who will work with the regional coordinators to provide guidance, training and to develop best practices in order to ensure progress is being made toward the critical capacity in each region.

The regions may also choose to include Communicable Disease Liaisons, a position developed in Spokane Regional Health District (SRHD) to increase communicable disease reporting. These liaisons work with other public health communicable disease staff and notifiable condition reporters to build relationships which facilitate timely treatment, referral, and reporting of persons with notifiable conditions. These staff could also provide information about public health services and programs and disseminate updates about communicable disease treatment and control. They would work in the field to link providers and their staff with the experts at the LHJ, and perform other tasks necessary to meet the critical capacities.

Focus Area B, Section II, Critical Capacity A, <u>Benchmark 9</u>
Assess Capacity and Plan to Provide One Epidemiologist for Each MSA (>500,000)
Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
#9	Improve effectiveness of public health response	Convene regional working groups to discuss optimal staffing models	LHJ	Regional workgroups provide staffing models to achieve critical capacities	05/15/02
#9	Improve effectiveness of public health response	Develop position descriptions for state coordinators; recruit and hire Epidemiology and Response Coordinators at the state level	LHJ	DOH Coordinators Position Descriptions Developed State Coordinators hired	04/15/02 05/30/02
#9	Improve effectiveness of public health response	Conduct an initial assessment of current epidemiologic capacity in conjunction with focus area A[*]		Assessment tool created Pilot tested Administered Analyzed	5/01/02 6/01/02 7/30/02 8/15/02
#9	Improve effectiveness of public health response	Develop position descriptions for regional Response Coordinators	LHJ	Regional Coordinator Position Descriptions developed	5/30/02
#9	Improve effectiveness of public health response	Based on gaps identified in assessments, LHJs will recruit and hire Epidemiology and Response Coordinators at regional levels Recruit and hire Epidemiology and Response Coordinator in identified jurisdictions within region.		Coordinators hired	08/30/02
#9	Improve effectiveness of public health response	Conduct meeting with all regional Epidemiology and Response Coordinators; Work with regions having staff recruitment difficulties to provide training or other resources		Regional meetings conducted	09/01/02

---

[*] Focus Area Integration

Focus Area B, Section II, Epidemiology and Surveillance

Critical Capacity B

To rapidly and effectively investigate and respond to a potential terrorist event, as evidenced by ongoing effective state and local response to naturally occurring individual cases of urgent public health importance, outbreaks of disease, and emergency public health interventions such as emergency chemoprophylaxis or immunization activities.

Existing Capacity

Timely reporting of notifiable conditions and communicable disease clusters to local health jurisdictions (LHJs) and by LHJs to the State Department of Health (DOH) is required under the Washington Administrative Code (WAC) 246-101. Timely investigation of notifiable conditions is also required by WAC. After-hours reporting numbers are available for some LHJs and for DOH; 24 hour contact numbers for key DOH personnel, LHJ staff, and other state agencies that might respond to a public health emergency are collected, updated and distributed to other public health professionals by DOH ("Red Book"). WAC requires veterinarians to report selected animal diseases. DOH manages a list serve (COMDIS) to provide a forum for interactive communications with public health disease control specialists across the state.

The ability to investigate and respond to naturally occurring cases or outbreaks of disease varies significantly among the LHJs in the state according to staffing, equipment and training resources. There is no detailed, standardized protocol describing minimum criteria for investigation and response across the state. DOH provides staff and resources as needed to all LHJs around the clock to take disease case reports, provide consultation, and activate the State Public Health Laboratories and Communicable Disease Epidemiology staff in the event of a public health emergency. DOH also coordinates investigations that cross jurisdictional boundaries.

Most LHJs have recent experience conducting outbreak investigations (between 1998 and 2000, 24 of the 34 LHJs in Washington State conducted one or more foodborne outbreak investigations) and a number have responded to diseases of public health importance with mass immunization or prophylaxis activities, including hepatitis A, pertussis and measles. In addition, DOH coordinates multi-jurisdictional investigations of foodborne disease outbreaks several times a year (there were eight such investigations between 1998 and 2000). There is currently no formal mechanism for review of these response and investigation activities.

Adequacy of Capacity

Public health capacity to respond to a large-scale outbreak, multiple outbreaks and other public health emergencies is limited, as discovered during the recent series of "anthrax" scares in Washington State. Experience has shown that even the largest LHJs are quickly overwhelmed by the epidemiological and logistical demands associated with even moderately sized naturally occurring disease outbreaks. Smaller LHJs have even fewer resources with which to investigate and respond to potential terrorist events or disease outbreaks. In addition, rapid notification may be limited for some LHJs by staffing and technology shortfalls.

The results of a field test of the proposed Standards for Public Health in Washington conducted in all LHJs in the summer of 2000 provides the basis for our understanding of this capacity. Specifically:

- 47% did not fully comply with a standard recommending written policies and procedures to delineate specific roles and responsibilities for local response to disease outbreaks or public health threats.
- 25% did not fully comply with a standard of providing phone numbers for weekday and after-hours emergency contacts available to local staff, the state department of health and appropriate local agencies
- 59% did not fully comply with documentation procedures for exercising legal authority for disease control
- 50% did not fully comply with initiating disease investigations within one working day
- Additionally 47% did not fully comply with the standard for routine evaluation and improvement of public health responses
- 78% did not fully comply with evaluation of outbreak response to identify areas for improvement.

Animal disease is reported infrequently and through informal mechanisms. The majority of LHJs and veterinarians are not familiar with the animal disease reporting requirements in WAC 246-101-405 and there are no protocols for DOH or LHJs to respond to reported animal disease cases or outbreaks, animal cases of potential bioterrorism agents, mass animal or bird deaths or illnesses or unusual animal disease syndromes, patterns or deaths.

Proposal for Effecting Improvements
- Develop standardized protocols for public health investigation and response to outbreaks or individual cases of public health importance and provide corresponding training
- Enhance epidemiologic staffing at selected LHJs
- Develop an evaluation tool for ongoing assessment of public health investigation and response
- Develop individual after-hours response plans at each LHJ
- Deploy PHIMS to LHJs and provide training
- Provide education, communication mechanisms and protocols to improve animal disease surveillance
- Expand current modes of communication and ensure messages can be delivered and received in secure, effective and timely manner.

Existing state and local protocols for disease outbreak, case investigation and case management will be reviewed in order to identify best practices. Following this review, standardized protocols that clearly delineate specific roles and responsibilities related to disease investigation will be developed. Best practices from state and federal agencies, particularly the University of Washington School of Public Health and Community Medicine's Center for Public Health Preparedness, CDC and other public health organizations (e.g. ASTHO, CSTE, NACCHO) will be collected and incorporated as appropriate. In addition, these protocols will be coordinated with environmental health and laboratory protocols.

Training for local, regional, and state public health staff will be developed addressing epidemiology, outbreak investigation, interpretation of clinical and laboratory information, public health control measures, communication systems, and management of secure information as it relates to the standardized protocols for naturally occurring individual cases of importance or outbreaks. Linking with Focus Area G,[*] training will be offered in a variety of formats, including video downlinks, ready-made informational materials, on-line resources, and in-person trainings. Training will be provided using a train-the-trainer model utilizing the regional Training Coordinators, allowing state, regional and local staff to train other public health, health care provider and hospital staff. In conjunction with Focus Area G,[*] an assessment will be conducted to determine the scope of necessary training including use of analytic tools.

An evaluation tool for public health response to outbreaks and selected conditions of public health importance will be developed to measure the timeliness and effectiveness of response, specifically focusing on disease investigation, communication, staffing, and compliance with the standardized protocols. Formal assessments of response at the state and local level will be conducted on an ongoing basis; these evaluations will be used to further develop and modify protocols and procedures for public health investigation and response. Lessons learned will be shared with other local, regional and state public health professionals through both formal and informal communication mechanisms including regular written communications (newsletters), electronic mechanisms (list serves and websites), and annual meetings of public health staff who are involved with response.

Epidemiologic capacity at selected LHJs will be enhanced through the addition of staff. As the public health regions vary widely in population, disease burden and capacity to provide health care, added epidemiological capacity within regions will help ensure sufficient staff to respond to disease outbreaks. Additionally, ongoing assessments may identify the need for additional capacity that could be addressed in future funding years.

Washington State Electronic Communication, Urgent Response and Exchange System (WA-SECURES) will be developed to provide an automated mechanism for rapid and targeted alerts to public health officials and others involved in public health emergency response through redundant call-down, broadcast fax, and on-demand conference calls (see Focus Area E Critical Capacity A, or Critical Benchmark 12[*]). In conjunction with this system, each LHJ must develop an after-hours response plan that includes continuous access to resources including trained staff, disease investigation protocols and quantitative data analysis methods. State, regional and local staff will collaborate to ensure appropriate standardized disease investigation and response tools including questionnaires and analytical capacity are available in each LHJ.

Public Health Issues Management System (PHIMS) (see Benchmark #8) is being developed to provide a mechanism which will improve accuracy of reporting by prompting the user with questions specific to each disease, including collection of specimens, laboratory tests, clinical observations, possible exposure sources, treatment, contact tracing forms. In addition, this system will include a mechanism to link associated cases as an outbreak is investigated. This secure, web-based application will record case information to an integrated data repository that ties individual case reports to longitudinal patient histories. Regional Epidemiology

---

[*] Focus Area Integration

Coordinators will provide PHIMS training to public health staff in their regions. DOH will explore the potential for PHIMS to be used as a vehicle to record chemoprophylaxis or immunizations in a public health emergency.

The DOH Public Health Veterinarian will collaborate with state, regional or local public health staff to develop strategies to increase veterinarian and public health awareness of animal disease reporting requirements. Training opportunities for veterinarians will be developed and deployed through a variety of means including websites, veterinary publications and newsletters, educational sessions at relevant conferences. DOH will also formalize animal disease reporting mechanisms between state and federal agencies, including the Washington State Department of Agriculture and USDA. In addition, DOH will identify and communicate with veterinary diagnostic laboratories in the state to find novel methods of identification and notification for zoonotic diseases of public health importance.

Animal disease reporting for selected diseases of public health importance will be developed into Public Health Issues Management System (PHIMS) version 2.0. Zoonotic disease investigation protocols will be developed for anthrax, brucellosis, psittacosis, rabies, tularemia, viral encephalitis, tuberculosis and plague. Response plans for these diseases will be developed and disseminated to LHJs, and incorporated into the statewide epidemiology response plan.

Existing communication mechanisms such as regional or local newsletters will be expanded to include policy makers and stakeholders to educate and inform these audiences about public health capacity and responsibilities, particularly as they relate to real-life natural and terrorism-related public health emergencies. Regional Response Coordinators will encourage local Board of Health members, County Commissioners and other local officials to attend exercises.

Although the statutory and regulatory structure of notifiable conditions surveillance has been reviewed and found adequate for conducting investigations and public health interventions, Regional Response Coordinators will provide training to educate key responders (health officers, elected officials, law enforcement) regarding public health authorities and responsibilities. Additionally Response Coordinators will work with the Focus Area A[*] Preparedness Coordinators in their region to develop written protocols and agreements for the coordination of enforcement activities.

Membership to various communication mechanisms will be expanded as appropriate to other public health emergency responders in the state. In addition, existing and developing communication mechanisms, including WA-SECURES, will be used to share information from EpiX, HAN, and other official emergency communications in a timely and effective manner. The state Response Coordinator will assure that multiple key disease investigation staff from each LHJ are represented on the COMDIS list serve and evaluate the effectiveness and timeliness of this means of communication.

---

[*] Focus Area Integration

Focus Area B, Section II, Critical Capacity B
Develop On-Going Effective State and Local Response …
Work Plan Timeline

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
BCCB	Improve state and local public health outbreak response	Develop standardized protocols for public health investigation of outbreaks or individual cases of public health importance	LHJ	Convene working groups on a regional basis to collect, develop and compile current best practices	8/15/02
BCCB	Improve timeliness and completeness of disease investigation	Develop an evaluation tool for ongoing assessment of public health investigation and response	LHJ	Create and test investigation evaluation tool	9/30/02
BCCB LINK A	Achieve 24/7 capacity for immediate response to public health emergencies	Develop after-hours response plans at each LHJ or region	LHJ	Create guidance for components of plans After hours plans developed	8/30/02 1/30/03
BCCB	Improve links between animal health community and public health	Provide education, communication mechanisms and develop protocols to improve zoonotic investigation for agents of highest concern	LHJ, Dept of Ag, WA Vet Assoc.	Poster of animal notifiable conditions disseminated Protocols for investigation of zoonotic agents of highest concern developed	9/30/02 12/30/02
BCCB LINK E, F	Improve communication system delivery and receipt of health alerts	Expand current modes of communication (e.g. EpiX, WA-SECURES, COMDIS); Identify and add members to alert systems	LHJ, labs HCPs/ Facilities, EM, Public Safety	Initial test of current alert system (COMDIS)	7/30/02
BCCB LINK G	Enhance staff competency to respond to public health emergencies	Provide training to state, regional and local staff concerning investigation and response protocols, PHIMS, etc	LHJ	Training provided to public health staff	Ongoing through regional meetings

91

Budget Narrative Focus Area B

(Incorporates all Critical Capacities)

Personnel ....**$ 398,446**

> 1 Washington Management Service II $ 5,505 X 12 = $66,060
> 1 Non-Medical Epidemiologist 2 (Epidemiology Coordinator) $4,500 X15.5 = $69,750
> 1 Non- Medical Epidemiologist 2 (Response Coordinator) $4,500 X15.5 =$69,750
> 1 Non-Medical Epidemiologist 3 (State Public Health Veterinarian) $5398 X 15.5 = $83,669
> 1 .5 Medical Epidemiologist 3 (Training Content Specialist) $4,167 X12= $50,005
> 1 .5 Information Technology Application Specialist 5 (Database administrator for PHIMS and the Disease Condition Database) $41,000
> 1 .5 Office Assistant Senior .5 X $2,350 X15.5 = $18,213

Fringe Benefits ....**$ 95,627**

> Calculated at DOH rate of 24% of salary.

Travel **$14,184**
- Direct travel expenditure is for the DOH Coordinators In-state travel (regional meetings, bioterrorism presentations for local agencies and tabletop exercises): Estimates are based on ten cross state trips at $150 per trip, 8 over-night travel stays at $125 lodging and per diem (average, Seattle and Spokane), and 2,700 miles of additional driving at $.345 per mile. (10 x $150) + (8 x $125) + (2700 x .345) = $3,421 X 4=$13,684
- In-state POV travel for Information Technology position between the DOH offices in Olympia, Washington and the DOH State Public Health Laboratories in Shoreline, Washington. = $500

Supplies **$28,920**
- Standard office supplies for the 5 DOH positions @ $480 X5 = $2400
- Telephone: $100/month x 12 = $1,200 X 5 = $6,000
- Information Services charge-back for (networks, software support, etc): 1,104/year X5 = $5,520
- Printing/Distribution of training materials: $15,000

Other **$20,200**
- Equipment (less than $5,000 individual)
  - 3 Laptop Computers @ $2,500 = $7,500
  - 3 Workstation Computers @ $2,000 = $6,000
  - 1 LCD Projector @ $3,000
  - Standard IT staff position desktop computer and monitor = $2,500
- Training registration and fees for DOH positions: $1,200

Contractual **$4,671,500**

      (PHIMS, LHJ Regional and Local Epidemiology Capacity, Training, Syndromic Surveillance)

PHIMS Development (Critical Benchmark 8)	Cost
Public Health Issues Management System Version 1.0 This expenditure allows the final phases of construction of the initial version of PHIMS to occur, and provides for implementation of PHIMS across Washington. The contractor is Olympic Consulting Group, of Federal Way, Washington.	$350,000
Public Health Issues Management System and Disease Condition Database Integration and Messaging This expenditure allows for final convergence of the PHIMS 1.0 Database with the DCD 1.0 Database. The contractor is IRM Services Group of Olympia, Washington.	$75,000
Disease Condition Database QA Interface This expenditure will allow for the creation of a manual interface for DOH epidemiologic staff to perform quality assurance functions on completed case investigation reports. The contractor is IRM Services Group of Olympia, Washington.	$30,000
Disease Condition Database NNDM Interface and COMDIS Migration This expenditure will allow for the conversion of historical data for the COMDIS database and for the creation of the interface from the DCD to the CDC's Nationally Notifiable Disease Module.	$80,000
PHIMS 2.0 This expenditure will provide for contracting resource for a second version PHIMS. This version is specified to include full integration with the Lab Reporting systems as proposed in Focus Area E and complete integration with the Alert and Notification features of the Health Alert Network. PHIMS 1.0 will also incorporate all changes to the data model specified in the NEDSS Logical Data Model Extension of the HL7 Reference Information Model. The contractor for this version will be selected via competitive bid.	$300,000
LHJ Implementation of PHIMS 1.0 This expenditure will provide for assistance from Olympic Consulting Group in the implementation of PHIMS 1.0 for local health jurisdictions across Washington.	$10,000
System Documentation and Training Materials This expenditure will allow for the creation of training materials for use by PHIMS and DCD users and for technical specifications and guidelines for use by WEDSS Data and Application Section staff members.	$10,000
Total Contractual for PHIMS Development and Implementation	**$855,000**

Proposed Lead and affiliated counties with estimated regional and LHJ specific funding for additional epidemiology capacity

Lead and Counties	Population (rounded)	$ Per County	Regional $	Regional Training $	Tl. $ in Region
Bremerton-Kitsap	233,000		220,000	10,000	230,000
Clallam	65,000				
Jefferson	26,000				
	324,000				
Thurston	210,000		220,000	15,000	235,000
Lewis	69,000				
Pacific	21,000				
Grays Harbor	68,000				
Mason	49,000				
	417,000				
Southwest (Clark & Skam.)	363,000		220,000	15,000	290,000
	94,000	55,000			
Cowlitz	4,000				
Wahkiakum	461,000				
Pierce	713,000	110,000	220,000	25,000	355,000
King	1,758,000	412,500	220,000	50,000	682,500
Snohomish	618,000	110,000	220,000	35,000	475,000
Skagit	104,000	55,000			
Whatcom	170,000	55,000			
Island	72,000				
San Juan	14,000				
	978,000				
Chelan-Douglas	99,000		220,000	7,000	227,000
Okanogan	39,000				
Grant	75,000				
Kittitas	34,000				
	247,000				
Benton-Franklin	195,000		330,000*	20,000	350,000
Walla Walla	55,000				
Yakima	224,000				
Klickitat	19,000				
	493,000				
Spokane – North	422,000		220,000	20,000	240,000
NE Tri	59,000				
Lincoln	10,000				
	491,000				
Spokane – South	---		110,000	3,000	168,000
Whitman	40,000	55,000			
Garfield	3,000				
Columbia	4,000				
Adams	17,000				
Asotin	21,000				
	85,000				
Total	5,967,000	852,500	2,200,000	200,000	**$3,252,500**

*$110,000 for epidemiology capacity in Yakima

- Regional Epidemiology Coordinators $110,000 X10 = $1,100,000 (includes salary, benefits and equipment for 15.5 months)

- Regional Epidemiology Response Coordinators $110,000 X10= $1,100,000 (includes salary, benefits and equipment for 15.5 months)
- Other Enhanced Epidemiology Capacity identified regions $110,000 X 7.75 = $852,500 (includes salary, benefits and equipment for 15.5 months)
- Training Stipend divided among the regions =$200,000

Object of Expenditure	Syndromic Surveillance	TOTAL
LHJ Personnel (salary and fringe)	Epidemiologist Administrative support	$114,000
Personnel consultation	.8 FTE Informatics Consultant plus Programmer time	$300,000
Add additional LHJ	Epidemiologist + associated hardware/software + programmer time	$150,000
Total		**$564,000**

Total Direct Costs. $557,377

DOH EHSPHL Division Indirect Charges ($557,377@ 7.7%)...................................$ 42,918

DOH Agency Indirect Charges ($557,377@ 13.6 %) ....$ 75,803

DOH Agency Pass-Through Indirect Rate ($4,671,500 @ 1.2%)..............................$ 56,058

Total Financial Assistance Requested...$ 5,403,656

Focus Area C - Laboratory Capacity - Biologic Agents
Washington State Public Health Laboratories (WAPHL)

The Washington State Department of Health Public Health Laboratories (WAPHL) is the primary public health-related laboratory organization in Washington State. As the lead bioterrorism response public health laboratory, it is an integral partner in the Laboratory Response Network (LRN) and has the capability of testing for the five major agents of bioterrorism (i.e., *Bacillus anthracis, Yersinia pestis, Francisella tularensis, Brucella and Clostridium botulinum* toxin) and has been designated as a Level C laboratory. As the state's reference clinical/environmental laboratory, the WAPHL provides local health departments, hospitals, clinics and commercial laboratories with a wide range of services including identification and confirmation of unknown pathogenic organisms, consultation on laboratory methodology and training in current laboratory issues and techniques. As a provider of services to local, state and federal agencies, the WAPHL is often the focal point for coordinating investigations and mediating the transfer of information between agencies. Microbiologists at the WAPHL test both clinical and environmental specimens associated with disease outbreaks and work with epidemiologists both at the state and local level, physicians and environmental health staff to identify possible sources for outbreaks.

The WAPHL supports a methods development staff that is working to improve and implement laboratory methods to enhance the state's capacity for responding quickly to emerging infectious disease and bioterrorism threats. The Laboratory has been a focal point both for the development and application of molecular methods used in public health surveillance efforts. These new methods hold great promise for the future of public health, and their development is made possible primarily through continued support of the Centers for Disease Control and Prevention (CDC) and academia, both at the national and international levels.

Laboratory Services
Critical Capacity A
Develop and implement a jurisdiction-wide program to provide rapid and effective laboratory services in support of the response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

Existing Capacity
During 1999, WAPHL received initial funding to begin developing capacity for bioterrorism (BT) preparedness and response. For the past two years, WAPHL has been functioning as a Level C laboratory in the LRN and is working in conjunction with one limited capacity Level B laboratory that is certified to process only two BT agents. The Level B laboratory in Washington State is Madigan Army Medical Center, located 50 miles to the south in Tacoma. There are 144 clinical laboratories in Washington that are eligible to become Level A laboratories in the LRN. The common communication methods employed by the WAPHL are telephone and FAX. Another form of communication used to reach laboratories is a Department of Health (DOH) newsletter called *ELaborations*.

In May 2001, the WAPHL distributed a survey to clinical laboratories to assess their capabilities for handling an incident of bioterrorism. Based on the data collected through the survey, the

WAPHL began, through an integrated cooperative training program, to educate Level A (and B) laboratories in Washington State about the LRN. So far, 35 laboratories have attended the first phase of Level A training provided by the WAPHL. The training is being delivered with the assistance of WAPHL staff through the existing WAPHL Laboratory Training program that has limited available resources. Training pertains to current federal shipping regulations, the identification of BT agents and chain of custody roles and responsibilities, based on current CDC guidelines. In addition to the training delivered to clinical laboratories to date, the WAPHL has provided training to many emergency response teams on the proper collection, screening and shipment of possible BT agents to the public health laboratory.

Working closely with DOH epidemiologists, the WAPHL has a well-established on-call schedule that can provide urgently needed services 24 hours a day, seven days a week, as well as a system for reporting bioterrorism and outbreak results to the proper authorities. WAPHL has held many meetings with the State Bioterrorism Coordinator, state epidemiologists, HAZMAT teams, first responders and the FBI, to develop protocols for collection, delivery and testing of specimens using LRN protocols, including chain of custody forms. The existing infrastructure can also be utilized for collecting samples for the analysis of chemical agents associated with suspected chemical terrorism events. .

Adequacy of Existing Capacity
Although bioterrorism training for Level A/B laboratories and first responders is progressing well, limited resources have put constraints on the pace of critical training. Additional personnel are needed to allow the WAPHL to complete the current training cycle and then follow up with ongoing proficiency evaluations, continue training opportunities and maintain communication with laboratories within our jurisdiction. The WAPHL also sees a need to assemble a more complete list of first responders in the state so that training can be targeted to all those needing it. The integrated response plan, although well established and used, contains portions that currently rely primarily on the institutional memory of DOH staff. The overall plan needs to be integrated into a single cohesive document that can then be disseminated as necessary.

The above-mentioned forms of communication are inadequate. There is a definite need to improve the speed and accuracy of laboratory communications. Working relationships between Levels A /B labs and the WAPHL need improvement. Interactions between Level C and Level A laboratories are inconsistent and usually occur during outbreaks and special projects or as the WAPHL training program provides training opportunities. The WAPHL Training Program is currently at capacity. Projects, such as the "Level A Laboratory Training for Bioterrorism," caused the program to be at least three months behind in scheduling. Without additional resources, new training projects will create continued delays in the Program's schedule. Further, the existing program does not have the resources to follow-up training with proficiency testing, a necessary component of a rigorous laboratory response program.

The existing capacity for collecting samples to detect chemical agents is minimal. For example, there is currently a system in place for the collection and testing of blood for the presence of lead. Enhanced protocols and procedures need to be established for collection, transport and testing of blood and urine samples for analysis of other chemical agents.

Proposed Improvement(s)

1. Prepare a timeline for the development of a plan to:

   - Hire a Laboratory Program Advisor who is solely focused on communication and coordination between WAPHL and LRN laboratories in Washington State. The Laboratory Program Advisor provides support to the WAPHL director to ensure the pursuit, organization, management, and accomplishment of program activities.
   - Hire a Laboratory Information System Specialist to ensure the development of information systems within WAPHL and the ability to link those systems to state programs, LHJs and local area laboratories.
   - Develop laboratory based assessment workgroups (to include Level A/B laboratory representation) that focus on inter-laboratory proficiency testing programs and the improvement of networks for electronic communications. Developing an inter-laboratory proficiency testing program will assure that the Level A and B laboratories remain proficient at being able to "rule-in, rule-out or refer" potential BT agents. Developing such workgroups will bring experts in our area together and will serve to improve communications and build a stronger network of professionals dealing with the different aspects of bioterrorism response.
   - Survey additional Level A laboratories and local veterinary hospitals/laboratories within the jurisdiction to develop and maintain point-of-contact information.
   - Establish lines of communication with Level A laboratories and local veterinary hospitals/laboratories through site visits and regional meetings, broadcast faxes, newsletters and internet sites.
   - Educate Level A laboratories and the Poison Control Center on agents of bioterrorism, including rule-out testing, laboratory safety practices, safe specimen packaging and appropriate referral of test specimens.
   - Provide guidance for safe laboratory practices, quality control and quality assurance, and the adequacy of staffing and training in Level A laboratories within the jurisdiction.
   - Develop formal agreements with other reference laboratories for accessing their capability to perform the molecular subtyping of organisms, biosafety-level 3 testing and molecular methods for direct detection of microorganisms.
   - In collaboration with Focus Area E,[*] continue development of a network for electronic communications. This project would be an efficient method for communication and data transfer for all LRN participants. It would also provide a method for documentation of information and events. An e-mail list-serve and broadcast fax lists will need to be developed.
   - Improvement of interstate and international working relationships: Make contacts with our counterparts in international communities (i.e., Pacific Rim countries) to address the international trade of food and other commodities that could potentially be associated with foodborne outbreaks or bioterrorism threats.

Proposed Budget: An estimated $230,000 for FTE's, travel, office supplies, etc.

---

[*] Focus Area Integration

2. Develop an integrated response plan that directs how the laboratories will:
   - Formalize and implement inter- and intra- jurisdictional surge capacity. There is an imperative need to add additional Level B laboratories to the LRN in Washington State. Both the uniqueness of the state's population and geography to be able to provide adequate laboratory support during a BT event must be addressed. The Spokane Regional Health District (SRHD) Laboratory is located in the eastern region of our state near the Idaho border. This location, along with the population base of Spokane County, makes it an ideal laboratory to address the needs for BT response coverage in the eastern part of the state. SRHD Laboratory will also be providing surge capacity in processing BT specimens for the northern counties of Idaho. The Public Health-Seattle and King County (PHSKC) Laboratory is located in the most populated county of Washington. This county laboratory is also located in the same geographic location as the WAPHL and will serve as a surge capacity Level B laboratory. There should be a focus to bring these county laboratories up to Level B status. Other laboratories in Washington State (i.e., the Washington State Animal Diagnostic Laboratory [WADDL] in Pullman and the University of Washington Clinical Laboratory in Seattle) have indicated an interest in serving as surge capacity laboratories and are willing to collaborate with WAPHL to provide a coordinated response to BT events that involve potential clinical and/or animal infections.
   - Organizing and conducting bioterrorism response training workshops in remote locations (Link with Focus Areas A, B & G[*]).
   - Educate/Train LRN laboratories on agents of bioterrorism, including rule-out testing, safe specimen packaging and appropriate referral of test specimens by conducting jurisdiction-wide training workshops and educational seminars.
   - Identify and list, through development of a database, Level A and B laboratories within the jurisdiction and define roles, responsibilities and capacities.
   - Assess "Rule-Out or Refer" capability with challenge sets simulating agents of bioterrorism.
   - Coordinate with the State Health Officer and epidemiologists to improve the communication plan protocol for release of laboratory results related to bioterrorism or other outbreaks (Link with Focus Areas A, B & F[*]).
   - Acquire equipment to communicate more effectively with LRN laboratories, the law enforcement community, others within the public health laboratory community, CDC, and the public.
   - Collaborate with Focus Area B to develop rapid testing to "Rule-Out" varicella-zoster virus as part of protocol for monitoring dermatological conditions/rash illness.
   - Participate in the establishment of secure electronic linkages for reporting real time bioterrorism lab results to local public health and law enforcement agencies (Link to Focus Area E[*]).
   - Refine/improve protocols and acquire supplies for safe transport of specimens by air and ground

Proposed Budget: An estimated $430,000 to include SRHD and PHSKC; Other Level B labs; supplies, travel, shipping mailers and communications equipment.

---

[*] Focus Area Integration

3. Establish operational relationships with local HAZMAT Teams to:
   - Develop a database to organize points of contact with HazMat teams, first responders, FBI and the Poison Control Center in Washington State.
   - Cross-train the Laboratory Program Advisor to assist and represent the State Laboratory Bioterrorism Coordinator, as necessary (Link with Focus Area B).
   - The Laboratory Program Advisor, together with the Bioterrorism Coordinator, may organize/coordinate training workshops to educate law enforcement agencies for proper sample collection, initial screening, shipping and chain of custody.
   - Enhance/develop the management of laboratory operational activities (such as specimen receipt, testing, and reporting of lab data) to ensure optimal support within WAPHL.
   - Meet with key partners to establish plans and procedures for use in times of increased bioterrorism activity.

Proposed Budget: An estimated $35,000 to include basic supplies.

4. Enhance relationships with community laboratories, etc., to:
   - Continue website development of bioterrorism-related materials: Mailing/Packaging requirements; training opportunities (Link to Focus Areas F & G[*]).
   - Develop in-depth wet workshops for LRN laboratories.
   - Outreach to professional organizations and other laboratory groups in Washington through access to a satellite downlink for WAPHL (Link to Focus Area G[*]).
   - Coordinate with the Clinical Laboratory Advisory Council (CLAC) in the development of guidelines for managing bioterrorism events.
   - Work with CLAC to establish a bioterrorism committee that can be used to address questions and concerns among the laboratory community.
   - Continue to publish *ELaborations* as a means of updating the laboratory community on BT issues (Mailed monthly to over 2700 licensed laboratories in Washington State).
   - Develop and update a list of professional organizations and other laboratory groups in Washington and distribute among LRN members.
   - Participate in meetings with the State Advisory Committee on Public Health Preparedness and Response for Bioterrorism.
   - Bring together community laboratory practitioners, university laboratories and infectious disease physicians, as well as state and local public health laboratory practitioners in the design and execution of studies to assess and improve LRN laboratories.
   - Continue to present findings at national/international infectious disease meetings concerning assessment of molecular methodologies for agents of bioterrorism.

Proposed Budget: An estimated $35,000 to include travel and supplies for presentations and training.

9. Develop operational plans and train personnel to:
   The WAPHL will:
   - Review current specimen collection protocols for consistency with CDC procedures.
   - Develop protocols for shipping blood and urine samples from health care providers to WAPHL under appropriate conditions. Required training of personnel using these protocols will be provided by WAPHL.

---

[*] Focus Area Integration

- Coordinate referral of blood and urine specimens to CDC, or to a CDC supported laboratory, for analysis of chemical agents. Protocols will be consistent with CDC procedures.
- Develop a database for tracking and reporting of referred specimens to reference laboratories.

Proposed Budget: An estimated $30,000 for necessary supplies.

Focus Area C, Laboratory Capacity, Critical Capacity A
Work Plan Timeline

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
CCCA1	Prepare a timeline for the development of a plan to improve working relationships and communication	1. Hire a Laboratory Program Advisor 2. Hire a Lab Info (LITS+) Specialist 3. Lab based assessment workgroups 4. Survey additional Level A laboratories 5. Lines of communication with Level A 6. Educate Level A labs on bioterrorism 7. Formal agreements with reference labs 8. Network for electronic communications 9. Interstate & international relationships	Level A/B Labs; CDC; LHJ; WAPHL; UW; WSU; Federal Agencies; B.C.; CDC	• Employment offer recommendations • Training/Travel Documentation • Data Compiled • Database of Level A Labs • Training agenda; list of attendees • Develop MOUs • Document meetings; agendas	1. 08/02 2. 08/02 3. 11/02 4. 12/02 5. 01/03 6. 05/02 7. 06/02 8. 12/02 9. 06/02
CCCA2	Develop an integrated response plan that directs how the laboratories within your jurisdiction will respond to a bioterrorism incident	1. Inter- and intra- jurisdictional surge 2. Remote BT training workshops 3. Database of Level A/B laboratories 4. Assess "Rule-Out or Refer" capability 5. Improve plan for laboratory results 6. Equipment to communicate 7. Secure electronic linkages 8. Protocols/supplies for safe transport	Level A/B Labs; CDC; NLTN; WAPHL; LHJ	• MOUs • Training & QA/QC Documentation • Completed protocols	1. 06/02 2. 12/02 3. 11/02 4. 11/02 5. 01/03 6. 02/03 7. 01/03 8. 08/02
CCCA3	Establish operational relationships with local members of HazMat teams, first responders, and FBI	1. Database to organize points of contact 2. Cross-train Lab Program Advisor 3. Law enforcement training workshops 4. Work with key partners to plan	WAPHL; First Responders; LHJ; DOH EMS	• Training/Meeting Documentation	1. 08/02 2. 08/02 3. 11/02 4. 11/02

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
CCCA4	Enhance relationships with: community laboratory practitioners; university laboratories; and infectious disease physicians	1. Website development of BT materials 2. Develop in-depth wet workshops 3. Outreach to professional orgs 4. Develop guidelines for BT events 5. Continue to publish *Elaborations* 6. List professional orgs. & lab groups 7. Assess and improve LRN laboratories 8. Continue to present findings	Level A/B Labs; WAPHL; Physician Groups; Professional Organizations	• Schedules of Conferences/Rounds • Travel Documentation	1. 08/03 2. 08/02 3. 06/02 4. 08/02 5. 06/02 6. 09/02 7. 12/02 8. 12/02
CCCA5	Develop operational plans and train personnel	1. Review specimen collection protocols 2. Protocols for shipping 3. Coordinate referral of specimens 4. Tracking and reporting specimens	WAPHL; NLTN; CDC; Level A/B Labs; LHJ	• Training Documentation • Updated protocols	1. 08/02 2. 08/02 3. 08/02 4. 08/02

Focus Area C, Critical Capacity A-1, <u>Benchmark 10</u>

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
10	Laboratory Program Advisor	Recruit and hire	WA DOH Personnel; Other SPHL; State partners; NLTN	• Recruitment announcement • Offer of employment	08/02
	Laboratory Information (LITS+) Specialist	Recruit and hire	WA DOH Personnel; Other SPHL; State partners	• Recruitment announcement • Offer of employment	08/02
	Laboratory-based assessment workgroups	Inter-laboratory proficiency testing programs	Level A & B labs; CDC; State Training Coordinator	• Identify participants • PT plan in place • Communicate with LRN Labs for PT testing	11/02 11/02 01/03
		Improvement of networks for electronic communications	WAPHL; Level A & B Labs; WA PHL IT	• Draft of network plan • Documentation of partners coming on-line	12/02
	Survey of additional Level A laboratories	Survey laboratories	Level A Labs	• Final draft of survey • Survey result summary	08/02 10/02
	Establish Lines of Communication with Level A & B Labs	Site visits	Level A & B Labs; CDC; Other SPHL; Other WA State Programs	• Travel documentation	09/02
		Regional meetings	LHJ; NLTN; CDC; State Train Coord; Level A/ B Labs	• Travel documentation	10/02
		Broadcast faxes	LHJ; Other SPHL; Level A/B Labs; DOH Program	• Fax documentation	08/02
		Newsletter	LHJ's; State Train Coord; Level A/B Labs	• Copy of newsletter articles	06/02
		Internet sites	LHJ; Level A/B Labs; WA PHL IT staff	• Documentation of website address	08/03
	Level A laboratory training	Rule out testing	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Laboratory safety practices	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Safe specimen packaging	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		Appropriate referral	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
	Provide guidance to Level A & B Labs	Safety practices	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Quality control and assurance practices	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Adequacy of staffing	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
		Internal Training within Level A laboratories	LHJ; NLTN; CDC; State Train Coord; Level A/B Labs	• Training documentation • Travel Documentation	05/02
	Develop Agreements with higher level labs for assessment of molecular capabilities	Perform molecular subtyping, BSL 3 testing & molecular methods for direct detection	Level B Labs; CDC; LHJ	• Level B Cooperative agreements • Proficiency testing documentation	08/02
	Electronic communications network	Collaboration with Focus Area E & Planning	IT services; LHJ; Level A/B Labs; CDC	• Planning documentation	08/03
	Interstate and International working relationships	Contacts with counterparts in international communities	International public health agencies; CDC; Other SPHL	• Planning documentation	06/02

Focus Area C, Laboratory Capacity, Biologic Agents
Laboratory Infrastructure

As a member of the Laboratory Response Network (LRN), ensure adequate and secure laboratory facilities, reagents, and equipment to rapidly detect and correctly identify biological agents likely to be used in a bioterrorist incident.

Existing Capacity

The WAPHL Laboratory bioterrorism (BT) response team consists of trained laboratory personnel and a Ph. D.-level Molecular Epidemiologist. In addition, laboratory staff from other sections have been cross-trained to help during an outbreak or BT event. So far one staff member has received Level B training from CDC. Protocols and reagent kits for the submission of both routine and BT specimens to the WAPHL are in place. LRN BT protocols have been adapted for use at the WAPHL. Recently the WAPHL Molecular Epidemiologist received training for molecular identification of bioterrorism agents at a CDC-sponsored workshop. Protocols are in place to triage specimens and the process is handled in coordination with State Office of Communicable Disease (CD) Epidemiology, housed in the same building with the WAPHL. Co-location enables rapid and frequent communication between both sections. CD Epidemiology screens requests from first responders and/or local health jurisdictions. Screening includes the assurance that the specimens meet specified testing criteria for acceptance and that they have moved through the proper channels. In addition to preliminary field screening for chemical, explosive and radiological agents, there are protocols in place to evaluate specimens for a credible BT threat. Epidemiology notifies the WAPHL of incoming specimens for evaluation/ testing. Critical agents are stored in a locked –70°C freezer and access to the room is controlled by an electronic keycard system that admits only authorized personnel. After laboratory testing is completed, notification protocols are followed. During the anthrax events of 2001, the WAPHL received the needed reagents for FA and rapid identification from CDC in a timely manor. The WAPHL also has dedicated staff to produce its own culture/testing media.

With guidance and funding from the CDC, the WAPHL has acquired critical instrumentation including TaqMan (ABI 7700) and Victor 2 for rapidly identifying specific agents of bioterrorism. After initial set up of the instruments, the CDC furnished supplies and reagents necessary for testing and validation. Under the direction of the WAPHL Molecular Epidemiologist, staff at WAPHL have been trained in the operation of these new instruments. Quality control samples received from the CDC were used to ensure the adequacy of staff training and to test the accuracy and reliability of the new systems. Protocols for using and maintaining the TaqMan and Victor 2 systems were incorporated into WAPHL procedure manuals. Communication with CDC technical support staff has been established to ensure that reagents are available and protocols for bioterrorism testing are current. At the present time, the WAPHL has enough reagents and supplies on hand for testing approximately fifty specimens for anthrax DFA/phage, plague DFA, tularemia DFA and botulism. WAPHL also has enough test reagents for 850 runs using TaqMan.

For many years, the WAPHL has routinely received isolates for identification of agents on the category A list. Since 2000, it has received samples for testing these agents related to potential BT events. Recently, WAPHL has also conducted two simulation exercises with first responders.

Adequacy of Existing Capacity

WAPHL is electronically connected to the LRN and receives timely e-mail notices on changes and updates of validation studies, and other information. WAPHL has trained staff for analysis of specimens associated with BT agents. There is a need to participate in regular simulation exercises set up with first responders and level A/B laboratories.

The existing capacity for testing using TaqMan and Victor 2 technology is only adequate under limited circumstances (during non-outbreak situations). Efforts have been made to ensure that sufficient testing capacity exists in Washington State by collaborating with other LRN laboratories. WAPHL has plans to extend partnerships with additional laboratories that will serve as surge capacity. Currently, the number of trained laboratory staff is not adequate. Resources are also needed to enhance storage space and security.

Proposed Improvement(s)

1. Develop operational plans and protocols that include:
   - Establish protocols for safe transportation of samples suspected to be BT-related, as well as other specimens of public health significance.
   - Purchase equipment and supplies to improve the safety of WAPHL and other Level B laboratory staff, including biosafety cabinets, other bio-containment measures, lockable freezers/refrigerators and incubators, personal protective equipment (See budget item in Critical Capacity A-2).
   - Hire additional qualified personnel necessary to use sophisticated instrumentation and other staff necessary to carry out the key BT, related activities of the WAPHL.
   - Develop a plan to train appropriate state and local public health laboratory staff in the use of the existing LRN protocols as well as new protocols as they are approved. Ensure an adequate number of trained staff to provide coverage during times of increased demand.
   - In collaboration with LHJs, train law enforcement and first responders in existing triage procedures for prioritizing intake and testing of specimens/samples before analysis.
   - Assess availability of quality assurance/quality control and proficiency testing materials. Design and implement mechanisms to deliver internal and external proficiency testing samples using simulated and non-select agent materials.
   - Update protocols for sampling, handling and transport of BT agents. Use protocols in training of Level A/B laboratories and first responders with the assistance of LHJs.

Proposed Budget: An estimated $546,000 to include 3 microbiologists, upgrade specimen receiving area and establishing proficiency testing for Level A laboratories.

2. Ensure capacity exists for LRN-validated testing…
   - Hire molecular microbiologists experienced in development and validation of assays for detection of infectious diseases (See #1, above).
   - Hire and train bench microbiologists to perform LRN validated procedures (See #1, above).
   - Purchase CDC approved laboratory equipment to meet the requirements of rapid identification methods. Smartcycler to provide real-time PCR for BT agents.
   - Current protocols in the public health surveillance system are focused on a few primary foodborne pathogens. In light of recent events in our country, and internationally, there is

an urgent need to expand the scope of these surveillance efforts by addressing additional organisms and bio-toxins, detecting disease trends more rapidly and disseminating data and information across the network more effectively. The methods in place must address rapid detection of multiple-loci of pathogens (using microarray, biosensors, etc.) and improved disease surveillance. WAPHL is planning to collaborate with the CDC's Division of Bacterial and Mycotic Diseases, to develop rapid, integrated laboratory diagnostic systems using advanced technology to detect, characterize, and investigate potential agents of foodborne terrorism. In addition to improving our preparedness and response to foodborne terrorism, the systems will vastly increase the efficiency of routine diagnosis, surveillance and epidemiologic investigations, thus improving our food safety system (Link to Focus Area B).

- The University of Washington Clinical Microbiology Division, proposes to participate with the WAPHL in development of rapid laboratory diagnostic assays for use in detection of pathogenic bacteria and fungi directly from clinical specimens and also for rapid confirmation of cultured organisms. These assays will be based on amplification techniques using real-time PCR methodologies and direct probe techniques using the principle of Fluorescence *In-Situ* Hybridization (FISH) in association with discreet diagnostic algorithms, and will primarily target systemic diseases (tularemia, brucellosis, yersiniosis, rickettsiosis) and diseases of the respiratory tract (pulmonary anthrax, Q-fever, coccidiomycosis, among others).

- Surveillance for unexplained critical illness and death is a key public health strategy for detecting emerging infections and possible incidents of bioterrorism. For surveillance to be successful, critical illness and deaths that may have an infectious disease etiology should be reported before a final diagnosis is established. Unexplained critical illness or death was added as a notifiable condition in December 2000 to improve the timeliness of disease reporting for emerging infections and potential bioterrorist threats. We expect approximately 120 cases of unexplained critical illness or death to be reported annually in Washington State. WAPHL plans to increase laboratory capacity that will assist in specimen storage for six months and, if necessary, referral to CDC for further testing (Link to Focus Areas B & E).

Proposed Budget: An estimated $231,000 to include DNA Extractor and MIDI System, etc.

3. Ensure at least one public health laboratory…
   - Purchase CDC approved laboratory equipment that meets the requirements of rapid identification methods. SmartCycler and Thermocycler to provide timely and cost effective handling of infectious disease specimens; DNA Sequencer to apply molecular epidemiologic methods to outbreak investigations and surveillance (See: Focus Area B, Critical Capacity D.7-f)
   - Improve surge/backup molecular methods capacity through collaborations with proposed Level B laboratories.
   - Update existing protocols for new advanced rapid identification methods and incorporate into current testing algorithm.
   - Establish expanded protocols for foodborne testing (CDC collaboration) to include botulism, etc. in food and water.

Proposed Budget: An estimated $226,000 to purchase lab equipment and update existing protocols.

4. Conduct at least one simulation exercise per year…
   - Develop a plan to assess rule-out capability, as part of a simulated exercise, with challenge sets simulating agents of bioterrorism and implement the plan.
   - Develop a plan to assess availability of proficiency testing materials and design and implement mechanisms to deliver proficiency testing samples.
   - Schedule and participate in simulation exercises with state LRN laboratories.

Proposed Budget: An estimated $15,000 to develop proficiency testing plan.

5. Ensure at least one operational Bio-Safety Level 3 (BSL-3) facility…
   - Develop partnerships with other Level B laboratories to serve as back-up BSL3 facility in the event that WAPHL facility becomes inoperable. Ensure that they have identical safety/security standards.
   - Enhance protocols to allow existing BSL2 facilities to follow BSL3 practices as outlined in the CDC-NIH publication "Bio-safety in Microbiological and Biomedical Laboratories, 4th Edition" (BMBL).

Proposed Budget: An estimated $55,000 for supplies.

6. Ensure that laboratory security is consistent, at a minimum with the guidelines…
   - Upgrade the security of the WAPHL to meet guidelines set forth in BMBL, Appendix F. This will include bringing in consultants and implementing their recommendations to upgrade building security (i.e., video surveillance, perimeter security, etc.).
   - Develop protocols to assure that first responders have screened for radiological, explosive, and chemical risks prior to receiving specimens.
   - Enhance or develop a laboratory information management system to ensure optimal laboratory support to public health partners and to provide efficiency in specimen handling and tracking.

Proposed Budget: An estimated $390,000 to include security upgrade and protocol development.

7. Enhance electronic communications within the LRN…
   - Purchase computer equipment with secure high-speed connection to the Internet protected by appropriate hardware and firewalls (Link to Focus Area E[*]).
   - Collaborate with Focus Area E[*] to ensure the utilization of NEDSS standards in development of information systems related to laboratory and partner communications, electronic exchange of laboratory-based data, electronic management of laboratory operations, and in development of laboratory and/or department-wide integrated data repositories.
   - Upgrade regional public health laboratories, such as Spokane Regional Health District Laboratory, in support of future LRN site enhancements (See also: Critical Capacity A: #2[*]).

---

[*] Focus Area Integration

- In collaboration with Focus Areas B and E,[*] and the WAPHL LQA and Training Programs, develop a database of private and public health laboratories within the jurisdiction, including their testing capabilities and capacities, and provide secure accessibility to partners in public health.
- Develop electronic communications to support proficiency testing programs that allow multicenter validation studies, coordinated by the CDC (Link to Focus Area E[*]).

Proposed Budget: An estimated $13,000 for supplies and meetings.

---

[*] Focus Area Integration

Focus Area C, Critical Capacity B, Laboratory Infrastructure

Work Plan Timeline

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
CCCB1	Develop operational plans and protocols	1. Hire additional qualified personnel 2. Safe transportation of samples 3. Purchase Safety equipment/supplies 4. Enhance existing triage procedure 5. Protocols for handling BT agents	Level A/B Labs; CDC; NLTN; DOH EMS; Consultants	• Offers of employment • Training Documentation • Completed Procedures	1. 08/02 2. 08/02 3. 12/02 4. 08/02 5. 08/02
CCCB 2	Ensure capacity exists for LRN-validated testing	1. Purchase approved lab equipment 2. Collaborations with CDC & UW 3. Critical Illness & unexplained death	Level A/B Labs; CDC; UW	• Purchase Orders • MOU	1. 12/02 2. 08/02 3. 08/02
CCCB 3	Ensure one public health lab has appropriate instrumentation and appropriately trained staff	1. Surge/backup methods capacity 2. Update protocols & incorporate 3. Establish food-borne test protocols	CDC; NLTN; Level A/B Labs	• Updated Methods • Agreements with Level B Labs for surge capacity	1. 08/02 2. 08/02 3. 12/02
CCCB 4	Conduct at least one simulation exercise per year	1. Assess rule-out capability 2. Assess availability of PT materials 3. Mechanisms to deliver PT samples	Level A/B Labs; DOH EMS	• Proficiency Documentation • Simulated Exercise Documentation	1. 03/03 2. 12/02 3. 12/02
CCCB 5	Ensure at least one operational Bio-Safety Level 3 (BSL-3) facility in your jurisdiction	1. Partnerships for back-up BSL3 2. BSL2 facilities follow BSL3 practices	BSL3 Consultants; Level B Labs; CDC	• MOUs • Enhanced protocols	1. 08/02 2. 08/02
CCCB 6	Ensure laboratory security is consistent with the guidelines set forth in BMBL and updates. Enhance laboratory security as needed	1. Upgrade WAPHL security 2. Screening samples by first responders 3. Enhance or develop a LIMS	CDC; Security Consultants; Other SPHL	• Reports from Consultants • Work Orders for Security • Protocols for distribution	1. 08/02 2. 11/02 3. 02/03
CCCB 7	Enhance electronic communications within the LRN	1. Purchase high speed equipment 2. NEDSS standards in systems 3. Upgrade SRHD Laboratory 4. Database of private and PHLs	CDC; DOH IT Staff; Level A/B Labs; LHJ; Other SPHL	• Work plan documentation • Procurement Requests • MOU	1. 12/02 2. 12/02 3. 08/02 4. 10/02

Focus Area C, Laboratory Capacity – Biological Agents

Critical Capacity: <u>A and B</u>
Budget

	Section:	Laboratory Services	Laboratory Infrastructure
	Critical Capacity:	A	B
Salaries		145,568	142,500
Benefits		34,936	34,200
Travel		18,400	5,000
Equipment			445,000
Supplies		44,773	5,000
Contractual		367,500	0
Other		30,900	769,688
	Sub-Total:	642,077	1,401,388
Indirect costs (21.3%)		58,485	134,723
Pass-Through Indirects (1.2%)		4,410	9,227
	Total:	704,972	1,545,337

A Short Budget Narrative

Laboratory Capacity (Focus Area C) is requesting a total of $288,068 in salaries to support a request for five FTE's. A total of $69,136 is requested in benefits (calculated at 24% of salaries). Travel in support of training, education of staff and in support of meetings is also requested. The equipment request focuses primarily on suggested improvements in infrastructure as outlined by CDC and on improvements to the PHL such as security enhancements and earthquake preparedness. Supplies are requested to support training and laboratory testing. Contractual funding is primarily in support of the development of Level B capacity in Washington State. Indirect charges are calculated based on DOH rates (see above). The total funding request for Focus Area C, Laboratory Capacity – Biological Agents, is $2,250,309.

Budget Narrative – Focus Area C

Laboratory Capacity – Biological Agents

This narrative documents budget information on SF 424A, Budget Information – Non Construction Programs, for Focus Area C of Washington State Department of Health's application, "Washington State Public Health Preparedness and Response to Bioterrorism."

Federal Funds Requested (column (e) of Sections A and B)

Personnel: .... $ 288,068

1	Lab Program Advisor (52K) - 15 months	$65,000
1	LIMS Specialist (62K) - 15 months	77,500
1	Micro III (52K) - 15 months	65,000
1	Micro I (40J) - 15 months	44,760
1	Micro I (40J) Existing - 12 months	35,808

> Note: New FTEs are calculated for 15 months
> Existing FTEs are calculated for 12 months

These positions are to be used directly by the WAPHL to upgrade bioterrorism (BT) response capacity and capability. The Lab Program Advisor (LPA) position will be used to assist the WAPHL Training Coordinator in the planning and training of Level A and B laboratory staff. The LPA will also coordinate Laboratory Response Network (LRN) proficiency testing for BT response in Washington State and assist in the coordination of WAPHL functions with the Office of Epidemiology and the Department of Health's Emergency Response System.

The Laboratory Information Management (LIMS) Specialist position will be a laboratorian who will work with WAPHL Information Technology (IT) staff to implement an up-to-date laboratory information management system at the WAPHL as suggested by the CDC. LIMS developmental work will include continuing development and testing of LITS Plus (a CDC application).

Microbiologist positions are to be used for enhancing the overall capacity of the WAPHL for response to BT, as encouraged in the Supplemental Bioterrorism Grant proposal. These positions will assist in the training of Level A and B laboratory staff; in development and implementation of new technology related to BT and emerging infectious diseases; and in adding capacity to the ability of the WAPHL to respond to a bioterrorist attack. The microbiologists will also be used to maintain up-to-date BT response procedures

Fringe Benefits: $69,136

Calculated at the current DOH rate of 24% of salary.

Travel: $23,400

Direct travel expenditures are as itemized below:

Out-of-State:	**Estimated Cost**
CDC Trip (3 @ $1,500)	$4,500

    WAPHL is requesting three trips to CDC during the 15 month grant period to meet with CDC counterparts and plan for BT response.

Virology Meetings (2 @ $1,500)	$3,000

    The WAPHL requests funding for two microbiologists to attend national virology meetings to discuss and plan for BT response during the 15 month grant period.

ASM/Workshop (2 @ $1,500)	$3,000

    Travel, per diem and registration costs are requested for two microbiologists to attend the annual conference and BT-related workshops at ASM.

EID Conference (1 @ $1,200)	$1,200

    Travel, per diem and registration costs are requested for two microbiologists to attend the annual EID conference.

In-State:	
Joint Health Conference (4 @ $500)	$2,000

    Each year the Washington State DOH sponsors a major conference for public health practitioners in the state. WAPHL is planning presentations to spotlight the LRN and WAPHL BT response training.

Regional Meetings (4 @ $500)	$2,000

    In collaboration with the Spokane Regional Health District (SRHD), the WAPHL is planning a series of BT training workshops for Level A labs. This is a continuation of the existing training plan. Funding is requested for four regional meetings.

Training Coord Travel, including Mileage (8 @ $525)	$4,200

    WAPHL requests travel funding for the PHL Training Coordinator to meet with Level B labs, LHJ representatives, the DOH EMS team and first responders in Washington State to plan BT response and for table-top exercises.

PHL Director Meetings & Workshops (2 @ $1,000)	$2,000

The WAPHL requests funding to support travel to meetings by the PHL Director for BT response planning.

Safety Conference (1 @ $1,500)	$1,500

Travel support is requested for the WAPHL Safety Officer to attend the 45th Annual Biological Safety Conference, October 20-23, 2002, in San Francisco, CA, related to laboratory safety and BT response.

Equipment $445,000

Item	**Estimated Cost**
SmartCycler (1 @ $70,000)	$70,000

This instrument will provide much needed surge capacity for handling agents of bioterrorism. The Smart Cycler [R] system is a highly versatile and efficient thermal cycler with real time optimal detection for today's molecular biology laboratory. The availability of this equipment will strengthen our ability to make rapid identification of bio-threat agents. This will allow for the rapid DNA detection to identify the presence of biological agents in a time-critical manor using a method called real-time PCR. This method is more sensitive and specific than other analytical methods, and can provide results in within 30 minutes, compared to other systems in the market.

DNA Extractor (1 @ $100,000)	$100,000

WAPHL needs to find protocols and instrumentation that provide speed, flexibility, and versatility. Our molecular biology laboratory is performing under the pressure of time and staffing constraints and wide-ranging detection requirements. This instrument will increase our capability and capacity to respond to a variety of infectious disease and bioterrorism agents in a timely fashion.

DNA Sequencer (1 @ $200,000)	$200,000

This instrument will increase our capability and capacity to respond to a variety of infectious disease and bioterrorism agents in a timely fashion. Out laboratory has been involved in developing different approaches to detect bacterial pathogens from the specimens by following16S rDNA sequence based approaches. This system will enhance our overall capacity to apply molecular epidemiologic methods to outbreak investigation and surveillance activity for disease like Hepatitis A.

Item	Estimated Cost
Thermocycler (1 @ $10,000)	$10,000

A thermocycler is requested, as part of CDC support funding, to replace a WAPHL PCR machine that is broken and beyond repair.

| GC-Ionscan® (1 @ $65,000) | $65,000 |

The WAPHL is requesting a GC-Ionscan unit for identification of chemical hazards in BT samples submitted for screening. This piece of equipment will ensure that samples can be handled safely by laboratory staff.

Supplies .... $ 49,773

Item	Estimated Cost
Spill Response Kit	$10,000

To meet new laboratory safety requirements, the WAPHL is requesting an emergency spill response kit. A spill kit is a set of consumable items used to clean accidental chemical spills. Chemicals available in the supply kit are used to neutralize hazardous chemicals.

| Basic support, supplies and materials | $13,773 |

As part of the funding request for BT response, the WAPHL is requesting support in the form of IT support, basic supplies and materials. These will be used primarily in support of the BT training efforts for Level A and B laboratories, LHJs, first responders, etc.

| Shipping supplies | $16,000 |

Recent changes in shipping regulations require the WAPHL to replace shipping containers (mailers) used in the transport of infectious substances. In order to meet current IATA standards for shipping, we request funding to replace outdated mailers and to provide containers for safe delivery of BT agents to the WAPHL and from WAPHL to the CDC.

| Proficiency Testing Supplies | $5,000 |

In order to provide an efficient and effective proficiency testing program for Level A and B laboratories, the WAPHL is requesting funding to support the purchase of supplies to support the BT Proficiency Testing Program planned for the coming year. Supplies will include tubes, mailers, slides, instructions, etc.

Item	Estimated Cost
Postage	$5,000

WAPHL has developed plans to support BT training, proficiency testing and the dissemination of educational material, in support of the LRN system. In order to provide this additional support funding is requested in the form of postage.

Contractual... **$367,500**

Item	Estimated Cost

Pass Through Contracts:

Pass Through Contract	$100,000

- Washington Animal Diagnostics Lab (WADDL)

- University of Washington (UW)

Pass through to PHSKC and SRHD is planned for development of Level B LRN capacity.

Funding will be conveyed through a non-competitive consolidated contract with DOH, such as are routinely used to pass through funds to local health departments.   Accountability will be achieved through contractual work plans and through peer relationships on the project work team.

Pass Through Contract to Public Health Seattle & King County	$100,000

The Public Health – Seattle & King County (PHSKC) Laboratory is a modern 5,000 square foot laboratory located at Harborview Medical Center in Seattle. The laboratory facilities are mostly Bio-safety Level 2 (BSL-2), but the 200 square foot TB lab is BSL-3.

The PHSKC Laboratory is staffed by 1.0 Laboratory Director, 1.0 Assistant Laboratory Director, 6.5 Microbiologists, 2.0 Laboratory Assistants, and 2.5 clerical staff. The laboratory staff perform approximately 480 microbiological and serological tests per day, Monday through Friday, or approximately 120,000 tests per year.

Item	**Estimated Cost**

The PHSKC Laboratory requests the items listed below in order to A.) provide surge capacity for rapid and effective laboratory services in support of the response to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies and B.) ensure surge capacity for adequate and secure laboratory facilities, reagents, and equipment to rapidly detect and correctly identify biological agents likely to be used in a bioterrorism incident.

1) 1.0 FTE Microbiologist for training, quality control, proficiency testing, and maintaining core capability as a Level A (clinical) laboratory to: a.) Perform rule-out testing on critical BT agents; b.) Safely package and handle specimens; and c.) Refer to higher level laboratories for further testing; and to ensure capacity as a Level B Laboratory Response Network (LRN) laboratory to perform LRN-validated testing for one or more of the BT threat agents on the Category A list (e.g., Bacillus anthracis, Yersinia pestis, Francisella tularensis, Clostridium botulinum toxin) $50,000 Per year

2) Class II Biological Safety Cabinet in the BSL-2 laboratory space to ensure worker safety while performing Level A laboratory rule-out testing for critical BT agents, handling specimens, and packaging specimens that are being referred to higher level laboratories for further testing

          $20,000 (one time)

3) Card-keys or similar devices to permit entry to the laboratory and to record all entries to the laboratory, and locks on freezers, refrigerators, incubators, and other containers where stocks of biological agents are stored to ensure laboratory security as specified in Bio-safety in Microbio-logical and Biomedical Laboratories, 4th Edition, Appendix F, to prevent unauthorized entry to the laboratory and to prevent unauthorized removal of dangerous biological agents from the laboratory $15,000 (one time)

4) Supplies and equipment needed to respond to disease outbreaks or bioterrorism events $15,000 per year

Pass Through Contract to Spokane Regional Health District	$167,500

The Spokane Regional Health District (SRHD) Clinical Laboratory serves the Spokane community with laboratory testing as Public Health support to our STD/TB/Refugee clinics. Since 1995 we have also served as a Regional Lab in partnership with the Washington State PHL, by providing STD

Item	**Estimated Cost**

lab testing for eastern Washington. This arrangement has served well to support the Public Health needs of our State. Moving into Bioterrorism testing in support of statewide needs is a logical progression.

We have a BSL3 containment lab that is used for Tuberculosis testing at this time. The BSL 3 was developed with some BT capability in mind, however on a basic scale.

At this time I would propose implementing BT testing on a staggered start up, beginning with *Bacillus anthracis*, then *Francisella tularensis*, *Yersinia pestis* and *Brucella spp*. over a two-year timeframe. The dollar amount requested would cover planning, additional equipment needs i.e. –70°C (key card secured) freezer, FA scope, balance, water baths, etc., staffing (a total of 0.75 FTE), updating the security to the area, training, and all expendable supplies, plus reagents, media, controls, proficiency testing, etc.

We would implement testing protocols in accordance with the LRN and work closely with WAPHL to maintain continuity of service and quality.

Staffing @ 0.75 FTE as a micro 3 (will include a Micro-biologist 2 or 3, Lab 1)

1) Assistant and Lab Aide, plus benefits): $46,000

2) Program directs + District Indirects: $14,000

3) Security - 2 keycard lock doors @ $2,000 ea plus "Lexan" safety glass in four windows @ $500 ea: $6,000

4) Training of Micro person(s) & Lab Aide (media prep):$5,000

5) Equipment: $96,500
   - Monitor and video recording: $5,000
   - Digital Camera: 600
   - Balance   1,600
   - FA Scope   15,000
   - -70°C Freezer-secure   13,000
   - Water Bath (2 @ $3,000 ea)   6,000
   - Heat Block   1,000
   - Vortex   300
   - Incubator (table top)   2,000
   - Refrigerator/Incubator (-20°C to + 60°C)   6,000
   - Autoclave, tabletop x 2   12,000
   - Miscellaneous Supplies   34,000

(Supplies include: Items listed in the LRN protocols not

Item	Estimated Cost

currently stocked plus reagents, media, controls, and
expendables)

Other: **$800,588**

Alterations and Renovations:

Contracts for Alteration/Renovation of PHL Specimen Handling	$338,888

A lack of adequate physical security and means of containing
accidental releases of biological, chemical or radiological
hazards from specimens was clearly demonstrated following
September 11. This component would address the recognized
deficiency by creating a separate accessioning area. The
renovated section would contain two biological safety cabinets
and one chemical fume hood for use in the opening of
potentially hazardous specimens. The accessioning area will
be designed to prevent the accidental release of dangerous
agents and thus minimizing risk to laboratory workers and the
environment

Contracts for Alteration - Video Monitoring System	$160,000

As part of the CDC-recommended security upgrades to the
WAPHL, a video monitoring system is planned to improve
laboratory safety/security.

Contracts for Alteration - Perimeter Alarm System	$135,000

As part of the CDC-recommended security upgrades to the
WAPHL, a perimeter alarm system is planned to improve
laboratory safety/security.

Contracts for Alteration - Concrete Bollards	$45,000

As part of the CDC-recommended security upgrades to the
WAPHL, a plan to improve the safety/security of the laboratory
is planned through installation of concrete bollards in key
locations.

Contracts for the Alteration - Earthquake Renovation	$90,000

The WAPHL is located in a seismic zone; making it vulnerable
to severe damage in an earthquake. Following a severe
earthquake in 2001, the DOH received recommendations for
upgrading the WAPHL facility.

Other Items (<$5,000):

Computers, Monitors & Software (5 @ $2,500)	$12,500

Five computers with monitors and supporting software are

requested to support each of the FTEs requested (see Personnel, above).

Projectors (2 @ $4,000) $8,000

   The WAPHL is planning an extensive and ongoing training
   program to achieve and maintain the proficiency of Level A and
   B laboratory staff in Washington State. Funding is requested
   for the support of this training through purchase of two
   projectors.

Respirator Charger (1 @ $800) $800

   Battery operated respirators used in the WAPHL BSL3 facility
   use rechargeable batteries. Currently the Laboratory has no
   means of recharging the batteries in-house. The WAPHL is
   requesting funds to purchase one respirator battery charger.

Refrigerators -Replacement of aging units (2 @ $4,200) $8,400

   The WAPHL needs to immediately replace two aging
   refrigerators in the Microbiology Section. Funding is requested
   to support purchase of the new units.

Fax Machines (2 @ $1,000) $2,000

   Funding is requested to purchase two fax machines at the
   WAPHL. These will be used to support BT reporting activities
   in Microbiology. New fax machines will allow rapid and
   efficient faxing of reports and messages to LHJ's and
   laboratories with limited computer support

Indirect Charges:..$206,844

Total Agency Indirect Rate	@ 21.3%	$193,208
Salaries & Benefits	21.3% x $357,204 =	$76,085
Travel	21.3% x $23,400	$4,984
Equipment	21.3% x $476,700	$101,537
Supplies	21.3% x $49,773	$10,602
Total Pass Through Rate	@ 1.2%	$13,636
Contractual	1.2% x $100,000	$1,200
Alterations and Renovations	1.2% x $768,888	$9,226
Pass-Through Contracts	1.2% x $267,500	$3,210

Calculated based on the Department of Health's federal indirect cost rate agreement. The DOH
indirect cost structure has a consistent department-wide rate of 13.6% and a variable rate for each
division which are applied to direct costs except for sub-awards, and pass-through (or "flow-

through") programs. For contracts over $20,000 and funds passed through to LHJ, the DOH indirect rate is 1.2%.

PHSKC has approved indirect rates, which are incorporated into the contractual amounts

Total Financial Assistance Requested.. $ 2,250,309

Focus Area E, Health Alert Network
Critical Capacity A

Ensure effective communications connectivity among public health departments, healthcare organizations, law enforcement organizations, public officials, and others as evidenced by: a) continuous, high speed connectivity to the Internet; b) routine use of e-mail for notification of alerts and other critical communication; and c) a directory of public health participants (including primary clinical personnel), their roles, and contact information covering all jurisdictions.

1. Assuring that 90 percent of the population is covered by the Health Alert Network (HAN). This activity is integrally linked to achieving Critical Benchmark #11.
2. Development of a communications system that provides a 24/7 flow of critical health information among hospital emergency departments, state and local health officials, and law enforcement officials. This activity is integrally linked to achieving Critical Benchmark #12.
3. Ensuring a directory of contact information necessary for implementation of the communications system described in #2 is up-to-date and complete.

Current Capacity

The Department of Health (DOH) initially received funding in 1999 to begin work in the development of capacity for bioterrorism preparedness and response through Focus Area E funding. In 2000, DOH received funding to begin work on elements of the National Electronic Disease Surveillance System (NEDSS). Washington has chosen to integrate the activities funded under Focus Area E, NEDSS, and general funds supporting information technology applications and databases for the Washington State Public Health Laboratories into the Washington Electronic Disease Surveillance System (WEDSS).

The goals of the WEDSS program are twofold:
- Develop secure, electronic mechanisms for public health agencies to receive, store, analyze and exchange disease and other notifiable condition surveillance data.
- Develop information distribution systems to alert public health authorities, broader public health systems and the health care workforce to information necessary for management of a public health emergency.

By integrating these activities in the WEDSS Program, DOH and Washington's local health agencies have been working in partnership and are positioned to have a highly integrated design that supports a variety of data and applications that will sustain and advance the practice of disease surveillance and public health laboratory diagnostic testing procedures. These elements working cooperatively with the ability to communicate in a secure fashion about these activities across the Public Health Emergency Response System (State and local public health, health care facilities, Laboratory Response Network, State and local emergency management agencies, State and local law enforcement agencies, fire departments, and emergency medical services providers) are critical to developing a flexible but complete communications system for Washington's management of a bioterrorism event or major biological incident.

Considerations:
1. DOH is expected by the local public health community and the health care delivery system to serve as a leader in the development of an integrated public health surveillance system. DOH is a convener of interest groups of local health practitioners and health care partners in the development of design details, and a service provider for public health surveillance and information distribution applications and mechanisms. These applications are most efficiently provided at the state level for use across the Public Health Emergency Response System.
2. The Internet is the ideal vehicle for linking data and information systems from state and local public health agencies (including communicable disease and vital records elements), health care providers, laboratories, health care facilities, and first responders. This is dependent upon connections that are securely established, data that are encrypted during transmission and standards for security and privacy that meet HIPAA requirements.
3. Information derived from the initial and detailed analysis of notifiable conditions case data must be delivered quickly, securely and in a targeted manner. This allows appropriate public health practitioners, health care professionals, and first responders to manage potential bioterrorism and communicable disease emergencies, to prevent emergencies from becoming more acute and to stem the source of disease.
4. Steps in database development, application development, and system development must occur incrementally. Each increment builds on previous successes.

Currently approximately 77% of Washington's population resides in a county that has a governmental computer network that is configured according to the architectural standards of the Health Alert Network. This enhancement of individual county networks connected to the Washington Intergovernmental Network (WIGN) has resulted from funding made available by first three years of the Health Alert Network project.

Enhancements to the current security capacity of the WIGN have provided the ability to enable secure access into the network by establishing a highly secure, Virtual Private Network (VPN) that includes local health department staff and the state and local emergency response personnel.

The Department of Health firewall, intrusion detection system, and DMZ were installed, the VPN design tested, and final implementation completed. DOH uses the infrastructure at the state level to serve as a resource for the transmission of secure communications through VPN technologies. DOH has become a certificate authority for Verisign IPSec certificates enabling the infrastructure developed among these laboratories, local health jurisdictions, and other DOH data trading partners. By providing this service each participating organization realizes a savings of approximately $10,000 in implementation costs.

Washington uses a list server distribution methodology for health alerts that sends information to executive managers and communicable disease contacts in each local health jurisdiction (LHJ) and has the LHJ distribute as appropriate to health care facilities, law enforcement agencies, fire departments, and emergency management agencies.

DOH maintains a paper-based listing of contact numbers and information for key staff at local health jurisdictions in its "Red Book". This pamphlet is updated biennially and provides a mechanism to reach key public health officials in an emergency on a 24/7 basis. LHJs, to

varying degrees of proficiency, keep and maintain contact information for their local Public Health Emergency Response Network partners.

Determination of Adequacy
The current level of 77% of Washington's population included in the HAN is not sufficient to assure 90% compliance.

The list server methodology is a good first step in the development of communications capacity between state and local health officials for health alerts. But a truly integrated system that directly reaches local law enforcement agencies, emergency managers, and health care facilities is not yet a reality. Additionally, the current system is based on a broadcast e-mail framework that does not reflect the need for a highly adaptable and flexible system that allows for messages to be delivered in a variety of redundant formats and in a truly targeted manner.

Much like the list server methodology, the DOH "Red Book" is a good first step. But the current paper based version does not provide the basis for an automated alert delivery system that allows users to generate and receive messages in a secure fashion, through a variety of media. The "Red Book" also does not include representation from health care facilities, local and state law enforcement agencies, and emergency management agencies. At the local level, there is no uniform consistency in how completely this information is maintained.

Proposed Improvement
As only 77% of Washington's population resides in counties that are covered by the Health Alert Network, DOH will work with the remaining counties to assure coverage. Of the remaining counties, Snohomish, Whatcom and Yakima counties have more sophisticated networks than the remaining counties that are part of the WIGN. DOH will work cooperatively with each of these counties to evaluate county level network infrastructure, identify appropriate hardware and software enhancements, develop purchase arrangements, and identify training resources for county information technology staff. The rest of the state is comprised of counties that have less sophisticated network infrastructures and will not require the complex analysis and detailed consultation for upgrading security infrastructures. These counties will be served by contracting with a network security consultant to purchase, install and train county information technology staff in the operation of the enhanced network infrastructure. In this budget period, Washington will further develop network architectural capacity with Chelan, Clallam, Cowlitz, Douglas, Grant, Grays Harbor, Island, Lewis, Stevens and Whitman Counties. The reminder of the counties will be configured to HAN architectural standards in the next budget period.

Washington surveyed its counties in 2000 to determine a variety of capacities that are critical to the computing infrastructure for the Health Alert Network. It is necessary at this time to build on that survey to understand current network capacity. Washington will assess the computing infrastructure of the public health system, the emergency management system, the law enforcement system, tribal nations, health care facilities and laboratories participating in the Laboratory Response Network.

Washington will implement the Washington State Electronic Communication, Urgent Response and Exchange System (WA-SECURES) integrates commercial off-the shelf software

applications (Microsoft Share Point, Content Manager, and COM 2001 Alexis) with an integrated statewide role-based directory. This allows for a secure web portal that will replace the functionality of list serves with the ability to place conference calls with appropriate state and local public health officials on a demand basis. It will also facilitate targeted and broadcast FAX, email, page, and text messaging alerts. It allows for document creation, collaboration and version control via a web interface. This sophisticated application will allow for a secure and virtual collaboration with anyone in the public health emergency response system via the use of the Internet. WA-SECURES will be deployed in stages, first to state and local public health agencies, then health care facilities, members of the Laboratory Response Network, emergency management agencies, and law enforcement agencies in phased increments. WA-SECURES will use the underlying directory of public health emergency response officials to locate them on a 24/7 basis. Should an identified official not be reachable, WA-SECURES will use the directory structure to assure contact with the designated back-up official. Directory information will by regularly updated and systematically exchanged with other states and the CDC.

Content resident on WA-SECURES will include information that is available to the public via the DOH Health Alerts and bioterrorism web site as well as more technical and audience specific materials available to members of the public health emergency response system available only through WA-SECURES. Decisions regarding whether content is available in a public manner or via WA-SECURES will be based on risk communication criteria generated by Focus Area F[*] activities. Development of a business process that allows LHJs, regional entities and DOH to maintain system level contacts for the directory will assure the continued connectivity of WA-SECURES.

Staffing associated with activities contained in this critical capacity will occur principally at DOH. Included among these staff will be the WEDSS Security and Infrastructure Team (WMS 2, the Health Alert Network Coordinator, an Information Technology Systems Specialist 5, and portions of the salary associated with the WEDSS Director, the WEDSS Technical Projects Coordinator, and the WEDSS Administrative Assistant). In addition, regional and local public health agencies will receive funds to train existing staff or hire new staff to perform technical support activities associated with accomplishing compliance within this critical capacity. The budget necessary for effecting improvements for this critical capacity is $1,163,273.

---

[*] Focus Area Integration

Focus Area E, Critical Capacity A, <u>Benchmark 11</u>
Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
A-1	Implement HAN Architecture	Snohomish County	SHD, SCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-02
A-1	Implement HAN Architecture	Whatcom	WCHHS, WCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-02
A-1	Implement HAN Architecture	Yakima County	SHD, SHCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-02
A-1	Implement HAN Architecture	Chelan & Douglas Counties	CDHD, CCIT, DCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Clallam County	CCHD, CCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Island County	ICHD, ICIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Grays Harbor County	GHHHS, GHCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Whitman County	WCHD, WCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Stevens County	NETCHD, SCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	8-03
A-1	Implement HAN Architecture	Cowlitz County	CCHD, CCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	
A-1	Implement HAN Architecture	Grant County	GCHD, GCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	
A-1	Implement HAN Architecture	Lewis County	LCPH, LCIT	Consultation, Evaluation, Procurement, Installation and Staff Training for HAN Architecture	

Focus Area E, Critical Capacity A, <u>Benchmark 12</u>

Work Plan Timeline

Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
A-2/BM 12	Develop Secure communication mechanism for Public Health emergency Response System	Finish configuration, procure Virtual Alert licenses, Develop business rules and training components for WA-SECURES	LHJ, WSHA, LRN, EMD, WASPC, Virtual Alert	Completion of initial development, licensing, training materials and processes	8-02
A-2/BM 12	Phase I Deployment of WA-SECURES	Deployment to DOH & LHJs	WSALPHO	Deployment in 90% of LHJs	11-02
A-2/BM 12	Phase II Deployment of WA-SECURES	Deployment to Hospitals	WSHA, LHJs	Deployment in 90% of hospitals	2-03
A-2/BM 12	Phase II Deployment of WA-SECURES	Deployment to Emergency Management Agencies	EMD, WSEMA	Deployment to State EMD and 90% of local EMDs	4-03
A-2/BM 12	Phase IV Deployment of WA-SECURES	Deployment to Laboratory Response Network	CLAC	Deployment to 90% of Level A, B, & C Laboratories	6-03
A-2/BM 12	Phase V Deployment of WA-SECURES	Deployment to Local Police, Fire, and EMS Agencies	Local EMD, WASPC, EMS Councils	Deployment to 90% of local first responders	8-03

Focus Area E, Critical Capacity B
Ensure a method of emergency communication for participants in public health emergency response that is fully redundant with e-mail.

1) Assess the capacity in your jurisdiction for redundant communication devices (two-way radios, cell phones, voice mail boxes, satellite phones, or wireless messaging), the capacity of existing systems at the state and local level to broadcast and/or autodial to automatically distribute alerts and messages to these devices, and the capacity to link to the emergency communication systems of local emergency response partners. If necessary, make improvements during this budget cycle.

2) Routinely assess the timeliness and completeness of the redundant method of alerting as it exists to reach participants in public health response.

Current Capacity
Washington assessed the utility and availability of redundant communication systems when surveying counties in 2000 to determine capacities critical to the Health Alert Network. The varied nature of Washington's geography does not make it possible to provide blanket coverage for any single form of redundant wireless technology. As a result, wired technology solutions (voice-mail and FAX) will by necessity play a role in providing a secondary level of redundant communications assurance. In urban centers, wireless technologies (cellular phones, wireless messaging) are available.

Currently Washington provides broadcast FAX alerts as a back-up means of providing health alerts to local health agencies. Many local health agencies in turn provide a broadcast FAX alert to critical members of the local public health system (health care facilities, health care providers, and laboratories). However, currently, there is no consistent level of relationship and communication between the governmental public health system, health care facilities and health care providers and the law enforcement and emergency management systems.

With that in mind there are a few paramount considerations:
1) The Internet is the ideal vehicle for linking data and information systems from state and local public health agencies, health care providers, laboratories, health care facilities and first responders; provided that connections are securely established, data are encrypted during transmission and standards for security and privacy meet HIPAA requirements. But it is also recognized that during terrorist events and natural disasters, e-mail and the Internet may not be functional and redundant communications may be necessary.
2) Information derived from the initial and detailed analysis of notifiable conditions case data must be delivered quickly, securely and redundantly in a targeted manner, where appropriate for public health practitioners, health care professionals, and first responders to manage potential bioterrorism and communicable disease emergencies, to prevent emergencies from becoming more acute and to stem the source of disease.
3) Steps in database development, application development, and system development must occur incrementally where each increment builds on previous successes.

Determination of Adequacy
Preparation and mobilization for a potential bioterrorism response includes the need to assure that all members of the public health emergency response system receive information in an automated fashion, and as such there is a need to expand current wire-based redundant communication systems. Wireless systems for redundant communications assurance have yet to be explored thoroughly. Absent a clear assessment of this, it is assumed that the current capacity is not adequate.

Proposed Improvement
It is necessary for Washington to build on the 2000 survey of local government and LHJ information technology capacity to better understand current redundant communications capacity. Washington will assess the redundant communications infrastructure of the public health system, the emergency management system, the law enforcement system, tribal nations, hospitals and laboratories participating in the Laboratory Response Network.

Based upon the results of that survey, an integrated strategy for procuring and developing redundant wireless and wire-based communication strategies will be implemented among a blend of cellular phones, personal wireless devices capable of secure communications, two-way radios, satellite phones. Additionally, expanding the communications loop to include law enforcement and emergency management agencies will assure more completeness and timeliness in the delivery of urgent communications via redundant means. Automated dialing voice-messaging and paging capabilities will be implemented as a key component of WA-SECURES. Additionally, existing voice based communications systems including two-way radios systems developed and used by emergency management agencies and the Washington State Patrol will be incorporated wherever feasible.

Developing the staffing component of these activities will require close coordination among all entities associated with public health emergency response. The Health Alert Network Coordinator will assure activities are aligned with the regional approach that Washington will employ for other areas of the supplemental workplan. Regional coordinators (as defined in regional work plans) will work with individual local health agencies as the lead agency for each county in developing an integrated system. Activities associated with this coordination will be developed under contract with the regional entities and individual local health agencies.

A critical component for assuring that redundant communication structures are functional is for routine and time testing of these communication models. State wide and regional alert drills will be conducted on a routine basis in an effort to determine the effectiveness and utility of these redundant communications systems. Funding for this activity is reserved in the amount of $105,220 for use in procuring redundant communications systems. These resources will be distributed at $8,000/region and $20,000 at the state level. Based upon the results of the survey the true cost of providing fully redundant communications methods could be far greater.

Focus Area E, Critical Capacity B

Work Plan Timeline

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
B-1	Evaluate PHERS Redundant Communications Capacities	Conduct a survey of local and regional capacities for redundant communications to include FAX, cellular, paging, wireless text, broadcast auto-dialing, satellite phone, two-way-radio	EMD, WASPC, ACCIS, LHJ, WSHA, LRN	Complete and evaluate the assessment	8-02
B-2	Develop a Procurement Scheme for Filling Identified Gaps in Redundant Communications Capacity	Identify best options for procurement of redundant communications for the Public Health Emergency Response System	LHJ, WSHA, LRN, EMD, WASPC	Conduct prioritization exercise and implement initial deployment of redundant communications equipment across the Public Health Emergency Response System	11-02
B-2	Evaluate the Effectiveness of Redundant Communication Methodologies	Design and schedule regular alert drills to evaluate the effectiveness of redundant communication methodologies	LHJ, WSHA, LRN, EMD, WASPC	First drill complete and regular drills scheduled.	1-03

Focus Area E, Critical Capacity C

Ensure the ongoing protection of critical data and information systems and capabilities for continuity of operations.

1) Assess the existing capacity in your jurisdiction regarding policies and procedures for protecting and granting access to secure systems for the management of secure information, system backups, and systems redundancy. If necessary, develop a proposal for improvements during this budget cycle.

2) Perform regular independent validation and verification of Internet security, vulnerability assessment, and security and continuity of operations practices, and rapidly implement recommended remedial activities.

Current Capacity
Public Health information systems constructed, housed or under development within Washington State fall into two categories:

- Centralized systems within the sphere of the Washington State, Department of Health
- Independent or distributed systems within the sphere of local health public and private entities.

There is a growing capacity for integrated systems as well as shared data interfaces. The use of Internet based applications and security technologies are showing a steady growth to accommodate the diverse partnerships. The need for high-level authentication, secured access, protected application environments, encrypted data exchanges and system redundancy grows steadily with the fielding of each application. Within the Department of Health, a series of recent efforts has established the beginnings of a strong architecture and an adequate security infrastructure, from which secured applications can be developed and deployed. The architecture and strategic plans includes firewalls, protected web environments, a single-sign-on portal utilizing X.509 PKI authentication technology and encrypted access. Applications targeted for this environment will also utilize secured messaging, secured data exchange, and LDAP technology. Technology exists for virus protection at the e-mail gateway and desktop or client environments within the department. Back-up and off-site storage requirements are currently addressed independently, application by application. A standardized enterprise-level strategy is in the planning stages.

Considerations:
1) The Internet is the ideal vehicle for linking data and information systems from state and local public health agencies, health care providers, laboratories, health care facilities and first responders; provided that connections are securely established, data are encrypted during transmission and standards for security and privacy meet HIPAA requirements. But it is also recognized that during terrorist events and natural disasters, e-mail and the Internet may not be functional and redundant communications may be necessary.

2) Information derived from the initial and detailed analysis of notifiable conditions case data must be delivered quickly, securely and redundantly in a targeted manner, where appropriate for public health practitioners, health care professionals, and first responders to manage potential bioterrorism and communicable disease emergencies, to prevent emergencies from becoming more acute and to stem the source of disease.

3) Steps in database development, application development, and system development must occur incrementally where each increment builds on previous successes.

Washington has adopted a method of authentication for X.509 PKI authentication and encryption. Transact Washington is a secure gateway designed for citizens and businesses that wish to conduct transactions with the State of Washington electronically.

With the use of digital certificates, Transact Washington creates a secure environment where citizens and businesses can complete online transactions with the State of Washington. For purposes of bioterrorism preparedness and response, Transact Washington is the ideal vehicle for establishing authentication and encryption at the individual level for personally identifiable health information. Currently DOH has established Transact Washington accounts for approximately 200 members of the state and local public health system.

Washington also uses server level certification and authentication for connections that are distributing data from a clinical or laboratory information management system to DOH. These certificates are provided by Verisign. They authenticate from the data trading partner to the DOH receiving server. This method of authentication allows for the creation of a virtual private network and secure socket layer tunneling between the data trading partners. Once connected these machines then allow an encrypted tunnel for the data transmission. Washington currently has 50 of these certificates in place.

Determination of Adequacy
In general, the architecture and strategic directions lay a good foundation from which to proceed for public health digital government applications and electronic interfaces between the Department of Health and its local partners. From a bioterrorism perspective there is a need to build capacity especially in the areas of numbers of secured systems, system redundancy, increased access by other emergency responder staff including law enforcement, emergency medical services, emergency management and local health care facility staff. Increased staffing is required for adequate 24/7 availability and support of critical systems. Drivers also exist for significant infrastructure growth relating to the number of firewalls, firewall-to-firewall secured connections, encrypted accesses and authentication mechanism. Further virus protection capacity is required at the application server layer for state-wide applications. The adequacy of virus protection capacity at the local level should to be assessed for size and scope of need. Capacity to remote application support using encryption technology will grow in parallel with the requirements to support 24/7 availability. Recognition exists of the requirement for regular security audits and penetration tests. Standard procedures for system and network backups and off-site storage are being developed for the DOH enterprise and will be made available to county information technology agencies as a best practices template. The complimentary components

for disaster recovery, including scheduled periodic testing of the recovery process, is yet to be addressed.

Proposed Improvement

Plans to build capacity are included with the implementation of each new health alert and bioterrorism preparedness system. Increased use of PKI technology for enabling authentication, secured messaging, secured access and encrypted data transfers is currently planned for each public health entity as systems come on-line in pilot and production implementations. Role-based authorization and selective authorization to information resources is planned using a combination of internal application security functions and the use of LDAP technology for resolving personal attribute data with identification data from personal digital certificates (PKI) technology. An assessment process is planned for anti-virus protection at the local level. An increased capacity for anti-virus protection is planned at the Department of Health for centralized statewide bioterrorism and health alert application servers. The department has begun planning for scheduled, contracted services to provide security environment and technology audits as well to provide periodic penetration testing services. Project assessment and development efforts are required for increasing capacity to provide a long-term 24/7 support strategy for and to provide greater depth for backup resources of primary support staff. Plans are required to address increased areas of infrastructure redundancy to address continual availability of secured systems including server and infrastructure fail-over capacity, raid storage technology data replication, backup, off-site storage, disaster recovery and hot site planning. Other necessary remediation activities will be developed as a result of the assessments that occur in each of the counties. It is unclear what remediation activities will be necessary, but it is assumed that these activities will require some level of resource to provide full remediation. In order to effectively provide remediation, $50,000 is reserved to effect improvements.

As the Public Health Issue Management System (See Focus Area B) is deployed to local health jurisdictions, hospital infection control practitioners, and infectious disease doctors, there is a need to purchase another 400 digital certificates, so that they may access the system. The certificates are approximately $99 per unit, or $38,600 is needed for this activity. It is also recognized that providing training and support to digital certificate implementation will require a coordinated effort between DOH, LHJs and county information technology agencies. For information system to public health system data transfer, Verisign machine-to-machine certificates are needed for all of Washington's counties, hospitals, and microbiology laboratories. These certificates are $130 per unit, and approximately 250 are needed for a cost of $32,500.

Additionally, an evaluation of other security technologies is needed that will help align Washington's health care facilities and health information services providers with security technologies that best integrate with the overall business needs of the health care facility or health information service provider for data interchange at the individual access level. This evaluation will determine the best way to bridge multiple security technologies in an effort to minimize duplication of technologies deployed at the user level and to assure that health care facilities are not employing multiple technologies at each site. $25,000 is necessary to work with the Washington Health Care Services Forum to conduct this evaluation and determine best practices.

The performance of independent validation of security technologies employed at DOH and LHJs is critical for providing the necessary assurance that systems designed to provide maximum security for public health data are truly secure. $50,000 is identified for the development of a master contract for an independent security to firm to perform independent evaluation and penetration testing.

Total resources identified for this critical capacity are $213,957.

Focus Area E, Critical Capacity C

Work Plan Timeline

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
C-1	Assess PHERS capacities across the state and regionally for access policies, security policies, system back-up policies, and system redundancy protocols	Conduct an assessment of each county information technology agency, hospitals, Laboratory Resource Network members, EMD and DOH	ACCIS, LHJ, WSHA, LRN, EMD, ACCIS	Complete and evaluate the assessment. Coordinate w/assessment activities in A-1/B-1	8-02
C-1	Implement indicated remediation activities	Provide necessary resources for the implementation of remediation activities	LHJ, ACCIS, DIS	Develop model policies, develop model for system back-up procedures and develop plan to assure indicated system redundancies	3-03
C-1	Provide Individual Access PKI through Transact Washington for users of PHIMS and the Electronic Data Transfer Hub	Purchase and deploy digital certificates to all LHJs and participating hospitals	LHJ, WSHA, ACCIS	Completion of installation and training in the use of certificates at the user level for all LHJs and for participating hospitals.	11-02
C-1	Provide server level security solutions to data trading partners	Purchase and implement Verisign machine certificates for data trading partners	LHJ, WSHA, LRN Members	The successful implementation and deployment of machine level certificates in conjunction with Critical Capacity D	8-03
C-1	Evaluate other individual access communication security technologies and determine best options for building necessary bridges between security structures.	Contract with the Washington Health Care Services Forum to evaluate and consider alternative, but equivalent security technologies for individual access	WSHA, WHCSF	Completion of evaluation and identification of practical alternative solutions and bridging mechanisms	4-03
C-2	Perform independent validation and penetration testing of critical computer systems	Develop a master contract for the provision of these services to DOH, LHJs and county information technology agencies	LHJ, ACCIS	Execute the contract and begin regularly scheduled validation and testing procedures.	4-03

Focus Area E, Critical Capacity D

Ensure secure electronic exchange of clinical, laboratory, environmental, and other public health information in standard formats between the computer systems of public health partners. Achieve this capacity according to the relevant IT Functions and Specifications.

1. Assess the existing capacity in your jurisdiction to exchange electronic data in compliance with public health information and data elements exchange standards, vocabularies, and specifications as referenced in the NEDSS initiative. (See Appendix 6, IT functions #1-9.) If necessary, develop a proposal for improvements during this budget cycle.
2. Ensure that the technical infrastructure exists to exchange a variety of data types, including possible cases, possible contacts, specimen information, environmental sample information, lab results, facilities, and possible threat information. (See Appendix 6, IT functions #1-9).
3. Regularly confirm the successful transmission and receipt of information to and from public health partners.

Current Capacity
Washington State has made substantial progress in electronic reporting. Under the CDC NEDSS initiative DOH has:

- Established a team with expertise in standards-based electronic data interchange in health care and public health
- Acquired and deployed generic interface engine software (New Era of Networks Adapter™ for EDI from Sybase)
- Implemented error checking procedures as part of active data brokering
- Implemented a backup plan including a second server running the interface engine and its associated databases
- Developed and implemented two clinical reference laboratory interfaces (Group Health Cooperative and Quest-Seattle)
- Developed and are preparing to implement an additional laboratory interface (Washington State Public Health Laboratories[*])
- Developed and are preparing to implement DOH's first non-laboratory interface (Children's Hospital and Regional Medical Center, Seattle)
- Begun development on two additional interfaces. (PAML, INHS)
- Implemented the HL7 message standard, using two different message types (the CDC's public health version of ORU^R01, and ADT^A08 for reporting birth defects data at time of patient discharge)
- Implemented the use of ICD codes for diagnoses and inpatient procedures, LOINC for laboratory tests and SNOMED for the results of those tests
- Implemented a VPN for secure delivery of data from partner institutions
- Implemented a secure server with access by token-based high-security digital certificates so authorized individuals at local public health jurisdictions and state public health programs can access the data which are collected centrally

---

[*] Focus Area Integration with C

- Joined HL7 (Washington DOH is an organizational member) and participated in voting.

Considerations:

1. DOH is expected by the local public health community and the health care delivery system to serve as a leader in the development of an integrated public health surveillance system, as a convener of interest groups of local health practitioners and health care partners in the development of design details, and as a service provider for public health surveillance applications when these applications are most efficiently provided at the state level for use across the public health system.
2. Centralized automated data capture and redistribution of electronic health data will provide more complete, accurate and timely data input to state and local public health authorities and is more efficient than requiring health care providers, laboratories and health care facilities to submit after the fact reports of disease incidence in a distributed manner to the state or county of the patient's residence.
3. Initial reports of disease incidence can be captured via data that are already electronic as a by-product of health care service delivery. This does not mean however that paper and voiced-based reporting will ever completely cease. Health care facilities and clinical laboratories will provide the greatest initial inflow of data that can be captured electronically.
4. Public health data collection systems designed on relevant data sources, rather than specific diseases or modes of disease transmission provide greater economies of scale and are less burdensome to the health care delivery system in total.
5. Developing HL7 interfaces appropriate for public health reporting can result in significant costs for institutions, especially when they need to contract with information system vendors for custom programming. Laboratories are especially hard hit because of the need to translate their own codes to LOINC and SNOMED. No law or regulation requires laboratories to use these codes and they are not necessary for reimbursement.

Determination of Adequacy
DOH's resource limitations to date result in an overall inadequacy for this capacity. Issues related to inadequate staffing, an inadequate applications environment, complete training, a lack of stability in its interface engine software, an inadequate disaster and recovery plan and a lack of real incentive for data trading partners to participate have made it difficult to move aggressively in this area.

Currently, DOH has a total of two staff members assigned to the EDI component. For most of 2001, DOH only had one staff member available for this activity. As a result, although DOH staff have the skills to bring on as many partners as needed, resource availability has severely limited the rate of progress. Furthermore, the transition from batch to real-time interfaces will require additional staff to develop, monitor and maintain the interfaces to ensure 24/7 availability.

When DOH obtained its interface engine in 2000, it was called "Paperfree" and was the flagship product of its company. Since that time the company has been acquired twice, most recently by Sybase, and the product renamed several times, most recently New Era of Networks Adapter™ for EDI. This organizational instability has meant that adequate support for the product has

sometimes been hard to obtain, although the situation has improved recently. It is not clear whether the product will be able to support some of the standards required under this initiative (e.g., ebXML, SOAP). We have also encountered a variety of limitations in the operation of the software. As we continue to build this mission-critical function we want to be sure that the software product we use is the best possible match for the needs of public health.

DOH provided a small amount of supplemental funding to one of the organizations (Group Health Cooperative) that are currently reporting electronically to us, and can attest that it greatly increased their responsiveness to our requests for electronic transfer of information. Working individually with laboratories and health care facilities is inefficient. This initiative should be an impetus for the CDC and other primary stakeholders in public health disease surveillance to persuade laboratory and clinical information system vendors to do the required code mapping for their systems as an industry standard.

Proposed Improvement
DOH will build on early successes in batch mode data transmission as a first step to achieving the goal of real-time data transmission. To accomplish this development DOH will need a staff member to serve as a data administrator and become expert in the middleware software; this will result in a total of 2.5 FTE with these skills. This level of resource is required as we move to the far more demanding environment of real-time messaging. This person will be part of the pool of resources that will allow DOH to move to 24/7 support of all mission-critical interfaces and applications.

DOH will also need an additional three staff members to do the time and labor-intensive work of negotiating the interface specification with our public health data trading partners. This will dramatically increase the resources allocated to this effort (from 0.5 to 3.5 FTE) and allow a much more aggressive approach to connecting with all 94 hospital and 141 clinical and public health laboratories in Washington State, to expand reporting to include all notifiable conditions under Washington law, and to add the syndromic and other data required for bioterrorism surveillance. Virtually all of the hospitals and laboratories have the ability to exchange data. Washington intends, in the development of this workplan, that economies of scale will be achieved in the development of laboratory and health care facilities by collecting data from existing networks of laboratories and health care facilities such as Inland Northwest Health Services, and Pathology Associates Medical Laboratories.

As new staff come on board, as current staff move to incorporate new required standards (ebXML, SOAP), as HL7 evolves to XML, and as the EDI function transitions from batch to real-time, staff will need considerable training. Current skills must be sharpened and new skills acquired. In the event that DOH determines that its current interface engine will not provide the level of functionality needed to meet the specifications in Appendix 6 to the Supplemental Workplan Guidance change interface engines, all staff will need immediate and intensive training in the new tool. In addition, DOH will work toward a goal for all staff building HL7 interfaces be HL7 certified. This is critically important as DOH moves to a much more demanding real-time environment for public health data exchange. Participation in standards development and training activities, including the CDC-sponsored data modeling and joint application development sessions scheduled to take place in 2002 is also critical to assuring that

DOH can fully meet the needs of this critical capacity. As a target for this budget period DOH will develop electronic system interfaces with data trading partners throughout the health care facility and clinical laboratory communities. DOH will also engage separate contracts to evaluate possible middleware solutions and disaster recovery plans, and will purchase a new application server for the middle ware product. DOH will also continue to work in a coordinated manner with the National Electronic Disease Surveillance System and with other national efforts at deve loping standards and vocabularies that will further facilitate public health data interchange.

Staffing associated with activities contained in this critical capacity will occur principally at DOH. Included among these staff will be the WEDSS Electronic Data Interchange Team (ITAS 5, three ITAS 3 and portions of the salary associated with WEDSS Director, the WEDSS Technical Projects Coordinator, and the WEDSS Administrative Assistant). Additional costs include necessary per employee charges (e.g. equipme nt, travel, supplies). The budget necessary for effecting improvements for this critical capacity is $684,210.

Focus Area E, Critical Capacity D

Work Plan Timeline

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
D-1	Assess existing capacity to exchange electronic data capacity across the state.	Assess each of the 94 hospitals and 141 microbiology laboratories to determine methods of data exchange currently available	WSHA, LRN, CLAC	Determine which laboratories and hospitals can exchange messages via HL7 format.	7-02
D-1	Determine which hospitals and laboratories can and should begin immediate electronic data exchange activities	Evaluate results of assessment. Prioritize hospitals and laboratories for implementation of electronic data exchange. Assess volume of reports, economies of scale within a network, and primary paper-based data trading partners current interaction with PH reporting	WSHA, LRN, CLAC	Completion of a prioritized list of laboratories and hospitals to implement electronic data exchange agreements	8-02
D-2	Ensure infrastructure exists to conduct data exchange for notifiable conditions in Washington	Hire staff, procure equipment, and provide training and other resources necessary to implement electronic data exchange capacity in Washington	HL7, CDC	Hire and train staff. Provide hands on-training in HL7, LOINC, SNOMED, ICD, and CPT. Develop technical architecture to implement inbound and outbound electronic messaging for PHIMS 1.0 and EDTH 1.0.	8-02
D-2	Ensure infrastructure exists to conduct data exchange for notifiable conditions in Washington	Develop messaging components of the system to populate PHIMS case records and DCD records	HL7, CDC	Automated data exchange from source point to PHIMS and DCD	8-03
D-2	Monitor EDI transmissions for indication of BT or disease outbreak	Develop aggregate data sets with the potential to indicate the utility of monitoring aggregate data for early detection of a BT event or disease outbreak	HL7, CDC	Creation of an aggregate data set available for algorithm development	8-03
D-2	Conduct evaluation of Sybase - New Era of Networks Adapter™	Determine the short, medium and long-term viability of currently used product	CDC	Complete evaluation, develop migration plan to new middleware tool as indicated	8-02

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
D-2	Implement EDI Activities	Negotiate data exchange agreements, establish QA process, develop interfaces, implement production level data flow for prioritized hospitals and laboratories	WSHA, CLAC, LRN	Production level EDI operational in prioritized hospitals and laboratories reflecting 80% of the volume of current case reports	8-03
D-2	Implement EDI Activities	Work with lower-priority laboratories and hospitals to determine necessary steps for implementation of EDI.	WSHA, CLAC, LRN	Identify action steps for remediation activities. Develop standard process for remediation, and initiate discussion with remaining labs and hospitals for EDI	8-03
D-3	Regularly confirm successful transmission of data exchanged with data trading partners	Develop quality assurance algorithms and techniques to evaluate how accurately data is being exchanged	WSHA CLAC, LRN	Completion of algorithms and techniques. Implementation of these tools to evaluate the effectiveness of data exchange agreements	8-03

Budget Narrative - Focus Area E (All Critical Capacities)

Salaries	780,707
Benefits	187,370
Travel	23,300
Equipment	124,000
Contractual	480,000
Supplies	33,624
Other	269,700
Sub-Total	1,898,701
Indirect costs	307,943
Total	2,206,644

Personnel **$780,707**

Critical Capacity A: Personnel costs associated with this activity include a WMS 2 manager to oversee the activities of the Washington Electronic Disease Surveillance System (WEDSS) Security and Infrastructure Team, and two Information Technology Systems Specialists 5: the DOH Firewall and Security Administrator and the WEDSS Hardware Technical Support Specialist. Other personnel supported include the Health Alert Network Coordinator – Epidemiologist 2 and 50% of the salary associated with the Director of the Washington Electronic Disease Surveillance System – WMS 2, the WEDSS Technical Projects Coordinator – WMS 2, and the WEDSS Administrative Support Specialist – Office Assistant Senior. Costs for currently approved positions are figured at 12 months salary. Costs for new positions are figured at 15.5 months salary.

Critical Capacity D: Personnel costs associated with this activity include an ITA/SS 6 to manage the activities and operations of the Washington Electronic Disease Surveillance System (WEDSS) Electronic Data Interchange Team, and (3) Information Technology Systems Specialists 3 to conduct data mapping and middleware operations using Sybase EDI Server. Other personnel supported include 50% of the salary associated with the Director of the Washington Electronic Disease Surveillance System – WMS 2, the WEDSS Technical Projects Coordinator – WMS 2, and the WEDSS Administrative Support Specialist – Office Assistant Senior. Costs for these positions are figured at 15.5 months salary.

(2) WMS 2 - $5,513/month x 15.5 months = $170,903
(1) WMS 2 - $5,513/month x 12 months = $66,156
(1) ITA/S S 6 - $5,513/month x 15.5 months = $85,542
(1) ITSS 5 - $4,990/month x 15.5 months = $77,345
(1) ITSS 5 - $4,990/month x 12 months = $59,880
(1) Epidemiologist 2 - $4,568/month x 15.5 months = $70,804
(3) ITAS 3 - $4,422/month x 15.5 months = $205,623
(1) Office Assistant Senior - $2,868/month x 15.5 months = $44,454

Benefits..**$187,370**

Benefits are calculated at 24% of the salaries described above.

Travel **$23,300**

Travel costs include POV reimbursement, in-state flights, in-state lodging, per-diem, out of state travel associated with the HAN national meeting.

Equipment **$124,000**

The following equipment is necessary to complete tasks associated with Critical Capacity A:
- WA-SECURES Web Server - $7,000
- WA-SECURES PBX Server - $12,000
- SSL Accelerators - $10,000
- PIX 515e Hardware - $5,000
- COM 2001Alexis Server License - $55,000
- Router External to DIS - $5,000
- Router External to Hanford - $5,000
- Router External to Richland - $5,000

The following equipment is necessary to complete tasks associated with Critical Capacity D:
- EDI Application Server - $20,000

Contractual **$480,000**

Contractual costs include:

Critical Capacity A:
- Virtual Alert Consulting and Maintenance - $85,000
- Costs associated with configuring the following counties to HAN Architectural Standards for data integrity protection and secure server to server communication: $150,000
  1. Chelan County - $15,000
  2. Clallam County - $15,000
  3. Cowlitz County - $15,000
  4. Douglas County - $15,000
  5. Grant County - $15,000
  6. Grays Harbor County - $15,000
  7. Island County - $15,000
  8. Lewis County - $15,000
  9. Stevens County - $15,000
  10. Whitman County - $15,000

Critical Capacity B:
- Costs included in this line item will be held for the purchase of redundant communications equipment, based upon needs identified in the assessment of county IT officials. Funds will be distributed to the lead LHJ in each region in the amount of $8,000. - $80,000

Critical Capacity C:
- An evaluation of other client level authentication and encryption technologies - $25,000 (Contractor to be identified)
- Contracts reserved for local government remediation activities - $50,000
- Master contract for security validation and penetration testing - $50,000 (Contractor to be identified)

Critical Capacity D:
- DOH Middleware Evaluation Consultation - $20,000
- EDI Disaster Planning and Recovery Operations - $20,000

Supplies **$33,624**

Standard Office Supplies for 11 DOH positions - $480 x 11 = $5,280
Telephone - $100/month for 11 DOH positions - $1100/month x 12 = $13,200
Information services charge back - $1,104/year x 11 = $12,144
Miscellaneous printing - $3,000

Other **$269,700**

Costs include miscellaneous equipment necessary to achieve Critical Capacity A:
- Desktop Computer - $3,000
- Office Furniture - $2,000
- Personal Digital Assistant - $400
- Cellular Phone - $200
- ISA Server - $3,500
- ISA Software - $3,000
- Active Directory Server - $3,500
- Active Directory Software - $3,000
- WA-SECURES Web Server Software - $3,600
- Associated Cables, Switches and Parts - $7,000
- Web Brick Server - $4,500
- Laptop Computer - $4,000
- LCD Projector - $3,000
- Virtual Alert Level 4 User Licenses (100 @ $495) - $49,500
- Virtual Alert Level 3 User Licenses (500 @ $130) - $65,000

Costs of miscellaneous equipment necessary to achieve Critical Capacity B:
- Costs identified herein will be held for the purchase of redundant communications equipment, based upon needs identified at the state - $20,000

Costs of digital certificates identified in Critical Capacity C:
- Transact Washington Digital Certificates (400) - $39,600
- Verisign Server Certificates (250) - $32,500

Costs of miscellaneous equipment necessary to achieve Critical Capacity D:
- 4 Desktop Computers - $12,000
- 4 Sets Office Furniture - $8,000
- 4 Personal Digital Assistants - $1,600
- 4 Cellular Phones - $800

Indirect Costs – Division of Epidemiology, Health Statistics, and Public Health Laboratories ($1,418,701 x 7.7%) - $109,240

Indirect Costs – Washington State Department of Health ($1,418,701 x 13.6%) - $192,943

Indirect Costs – Pass Through Rate ($480,000 x 1.2%) - $5,760

TOTAL COSTS .... Focus Area E - $2,206,644

Focus Area: F – Public Health Communication

Critical Capacity A

Provide needed health/risk information to the public and key partners during a terrorism event by establishing critical baseline information about current communication needs…identifying effective channels of communication for reaching the general public and special populations during public health threats…

Current Capacity

1) Interim plan for risk communication (includes Critical Benchmark #13.)

- The Washington State Department of Health (DOH) *Emergency Communications Strategy* (see **Critical Benchmark #13**) has been developed to provide public health information to media and the general public, as well as support public health message coordination to local health jurisdictions (LHJs) and emergency system partners in the event of a public health emergency. This strategy will work in concert with the DOH *Comprehensive Emergency Management Plan*, and in support of any existing LHJ emergency communications plans. (Interim plan includes strategies for media, Web, and general public.)

- The Washington State public health system currently consists of DOH, 34 LHJs representing 39 counties, private and public partners (such as health care providers, health care facilities, regional medical centers), related local, state and tribal government agencies, and community organizations. Many of these have emergency communications plans for addressing needs of their communities, but an overall assessment of system capacity has not been done.

2) Needs Assessment

- DOH and system partners are currently connected through a series of existing groups and communication channels including (but not limited to): listservs, DOH Web site, Washington State Association of Local Public Health Officers, Washington State Hospital Association, Northwest Center for Public Health Practice (NWCPHP), Washington State Board of Health, UW School of Public Health Practice and Community Medicine, Public Health Information Technology Committee (PHIT), the Public Health Improvement Partnership (PHIP) and associated committees.

- There have been communication, training and information technology assessments and discussions started/completed through the above channels; notably, the PHIP Communications Committee recently completed an extensive survey on the effectiveness of various public health messages with target audiences in Washington State. Additionally, in response to the events of September 11, 2001, DOH's Taskforce on Emergency Preparedness (TFEP) did an initial assessment of DOH and related system capacity including public health communication.

3) Strategies and Resources

- Strategies and resources were reviewed as part of TFEP's assessment.

- The DOH Web Bioterrorism Web site was developed to catalog related resources — developed by federal, state, and local entities—for target audiences including: General Public (English and Spanish speaking), LHJs and Healthcare Providers, and Emergency Responders. (Public Health-Seattle & King County has also developed a bioterrorism Web site to relay resources to target groups.)

- Existing strategies and resources have also been reviewed through the work of DOH's Office of Public Health Systems Planning and Development, NWCPHP, LHJs, and through other channels.

4) Spokespersons and Training

- Of 34 local health jurisdictions, four have full-time staff dedicated to communication activities. (Many larger hospitals and regional medical centers have communications staff, but smaller and rural hospitals do not.) All LHJs have identified spokespeople, but these are often Local Health Officers or others who have extensive additional duties.

- A few risk communication and media training opportunities have been offered to key staff within the public health system. Additionally, DOH's Workforce Development Office and the NWCPHP have identified related learning resources.

- DOH has a bioterrorism communications group—staff with scientific and communications expertise—to review related materials and key messages.

- Several DOH and LHJ communications staff (along with Emergency Management, Communicable Disease Epidemiology and others) have participated in related tabletop exercises and a National Pharmaceutical Stockpile training exercise.

Determination of Adequacy
1) Interim plan for risk communication

- While there is an interim *Emergency Communications Strategy* that will provide, through DOH, assistance to LHJs in the event of a public health emergency, and while communication channels exist to reach out to the state's public health system, there is no capacity at this time for overall coordination of necessary system-wide emergency public health communication planning, mentoring or resource development efforts.

- The system's capacity to provide the necessary pre-event public health message outreach and education to the general public, special populations and non-English speaking communities—as well as emergency messages in the event of an actual bioterrorism-related emergency—is inadequate.

- Communication resources are limited at the local level. For example: 29 LHJs have Web sites, but very few have the capacity to develop or maintain training or emergency resource information for target audiences within their jurisdictions; LHJs have developed relationships with special populations and communities within their jurisdictions but lack the resources to do effective emergency public health (bioterrorism) information campaigns to these communities.

2) Assessment

- There has never been a targeted (with specific LHJ and regional needs) system-wide assessment of emergency public health information communication capacity. In order to develop effective resources for the system, an extensive capacity assessment is necessary. As a starting place, aggregate information is available from Washington results of *CDC Public Health Performance Assessment for Emergency Preparedness,* and from assessment efforts noted in current capacity section above. (Note: Information technology assessment is part of Focus Area E;[*] additional training assessment is part of Focus Area G.[*])

3) Strategies and Resources

- DOH and LHJs need increased capacity—through a combination of centralized, regional and local resources—to better assess the needs of specific communities within their jurisdictions and to build a platform of effective resources.

4) Spokespersons and Training

- DOH and LHJs need increased capacity—through a combination of centralized, regional and local resources—to better assess the training needs of key staff and to participate in system-wide risk communication, emergency preparation, and media training and mentoring opportunities.

Proposed Improvements

An enhanced system-wide communication structure is necessary to support an effective emergency communications strategy, including:

- Provision of central coordination of system emergency public health communication resources through DOH Office of Public Health Systems Planning and Development to:
    - Meet system's need for coordinated and consistent public health messages regarding bioterrorism and public health emergencies.
    - Connect system needs with existing or necessary local, regional and system resources. Build platform of resources, and make available throughout the system.
    - Work in coordination with Washington State Electronic Communication, Urgent Response and Exchange System (WA-SECURES) to communicate emergency public health messages and information to system staff. Assist system staff with disseminating public health messages as appropriate to the general public and special populations using risk communication techniques. WA-SECURES will provide automated, rapid, targeted alerts to public health officials and others in a public health emergency through redundant call-down, broadcast fax, and on-demand conference calls. (see Focus Area E, Critical Capacity A and Critical Benchmark 12.[*])
    - Provide mentoring, and coordinate risk and emergency communication strategies and related training.

---

[*] Focus Area Integration

- The creation of regional emergency communications committees (with LHJs and other system members) to assess and address local needs. (Link with Focus Group A[*] for Assessment and emergency communications committee functioning as sub-group of LHJ Workgroup).

- Enhance DOH Communications Office response capacity to provide adequate interim and ongoing emergency communication support to LHJs and system partners.

- Develop emergency public health communication system testing procedures. (Link with Focus Area A[*] on testing procedures.)

- Build partnerships with organizations serving special populations to provide points of information dissemination and targeted training opportunities. (Provide support to LHJs for these efforts.)

- Create roster of qualified speakers (from scientific, public information and related disciplines) to act as resources in providing public health information response, and for providing presentations on bioterrorism and public health emergency preparation topics for priority/target audiences. (Including system staff, media, special populations, and communities.)

- Create and maintain resources/communication channels for DOH and LHJ staff for information on bioterrorism and emergency communications planning efforts, related updates, training calendar, staff roles and responsibilities.

- Create expanded resources for LHJs and system partners, including:
  - DOH Web - creation of sub-Web for system partners with training and resource library; expanded LHJ and provider portals; expanded information for general public and special populations. (Link with Focus Area E[*] to determine protocol for secure and general Web use.)
  - Risk communication and media training curriculum in various formats (electronic, video, classroom, text). (Link with Focus Area G[*] on curriculum delivery systems.)
  - Publication design and translation services. (Develop a tiered structure of LHJ priority needs and groups.)
  - Provide tools that can be localized (such as news release or publication templates); and emergency planning materials/assistance and outlines.
  - Provide expanded LHJ or regional staff/contractor resources (including LHJ support for related training or projects, regional coordination, contract assistance, as necessary).

---

[*] Focus Area Integration

Focus Area F, <u>Benchmark 13</u>

Develop an interim plan for risk communication and information dissemination to educate the public regarding exposure risks and effective public response.

When will the interim plan be activated?
The Washington State Department of Health (DOH) has developed comprehensive emergency communications strategies, channels, and partnerships to provide interim emergency communications assistance to the public and support to the state's (local) public health system.

The DOH Emergency Communications Strategy will work in support of any existing local health jurisdiction (LHJ) emergency communication plans. (DOH will provide additional assistance to LHJs currently without emergency communications capacity.)

The DOH Emergency Communications Strategy will be activated during Level 2 or Level 3 public health emergencies. Public health emergency response will be initiated by the Secretary of Health or designee.

Level 2 Emergency – Local or statewide public health emergency requiring coordination between DOH divisions or other local or state agencies, and stand-by, partial or full activation of state Emergency Operations Center (EOC). (Examples include significant communicable disease outbreak, radiation or hazardous material incident.)

Level 3 Emergency – Severe state or regional emergency requiring all resources to resolve and full activation of State EOC. (Examples include major earthquake or natural disaster, terrorist attack, bioterrorism event.)

Interim Plan Elements
1) The DOH Comprehensive Emergency Management Plan (CEMP) provides clear reporting and response structures to guide overall DOH response efforts in the event of a public health crisis, including:
   - Assessment and Response Team (ART) – Comprised of the Secretary of Health, and members of DOH Senior Management Team.
     - o ART assesses scope and character of emergency; manages overall response plan; notifies DOH staff, state and local agencies; appoints liaison personnel to state Emergency Operations Center, and other agencies and jurisdictions as necessary.

2) Working in concert with the CEMP, the **DOH Emergency Communications Strategy** provides detail for media, Web, public and partner response including mobilization of resources to provide integrated system response coordination. When a *Level 2* or *Level 3* emergency is called, the Communications Director (or designee) enacts DOH Emergency Communications Strategy. At that time, the Communications Management Team will assume emergency assignments as follows:

- *Communications Director (or designee)* serves with Secretary of Health as a member of ART. Primary duties include:
  - Media and issues planning and management as part of ART.
  - Priority media response.
  - Coordinate key messages for Secretary of Health and ART.
  - *Key contacts – Governor's Communication Office.*

- *Media Manager (or designee)* serves at the State EOC. Primary duties include:
  - Media and issues management and response as part of EOC.
  - Priority media response.
  - Coordination of media/key messages for DOH staff serving at EOC including State Health Officer and DOH Director of Risk Management.
  - Ensuring consistent public health messages in EOC products.
  - Ensuring DOH news releases and priority messages distributed throughout local emergency management agencies as appropriate (through state Emergency Management Division).
  - **Key contacts** *– State/local emergency response partners including State Emergency Management Division, State Patrol, Department of Transportation, and other state/local agencies as applicable.*

- *Web and Publications Manager (or designee)* serves at the DOH Communications Office. Primary duties include:
  - Media and issues management.
  - Activation of Communications Office emergency phone system, media alerts, Web messages, broadcast faxes and DOH staff and system e-mails.
  - Activation of DOH Emergency Communications Roster.
  - Management and assignment of information resources including: Public Information Officers, DOH Web Team, Emergency Communications Roster staff.
  - Media and public information coordination including call prioritization, news releases, information requests, division contacts and resources, broadcast fax, listserv e-mail messages and Web plans.
  - **Key contacts** *– DOH employees, local health jurisdiction and system (including designated hospitals and regional medical centers), Tribal Governments, CDC Communication Office, National Public Health Information Coalition, and auxiliary state agencies such as Department of Information Services.*

In coordination with the Communications Office Management Team and incident-related DOH divisions, DOH Public Information Officers, Web Team, and Emergency Communications Roster staff will assume emergency assignments including:

- *Media Response Coordination* – Track and log all media calls, inquiries and response efforts; record key and emerging issues, answer staff and LHJ inquiries regarding status of interviews, information distribution efforts, and issues.

- *Public Information Officers and Emergency Communications Roster staffing* – Create or distribute news releases, talking points, background information, fact sheets and other materials as assigned. Respond to general inquiries from media/staff/LHJ/public health

and system partners. Provide division/program and LHJ media assistance as needed. Provide research assistance.

- *Web Management* – Coordinate employee communications (intranet), media and general public messages (internet), and LHJ/provider/emergency responder alerts and information (internet). Ongoing Web updates and message maintenance. Work with DIS in the event of DOH Web server failure.

- *Administrative staff support* – Broadcast fax news releases and other information, as appropriate, to state media list, LHJs, and designated hospitals/regional medical centers; materials preparation support; general inquiries; other duties as assigned.

Communications Office/Emergency Plan Logistics:

- The emergency communications plan will be coordinated from the DOH Communications Office in Olympia.

- Emergency media hotline system is in place with all Communication Office lines streaming to one number when activated. (Additional lines as needed.)
  - o Existing Communications Office phone numbers will automatically transfer to central hotline.
  - o Central hotline number will be distributed to media, LHJs, partners.

- Plan in place to move Communications Office phones and functions to different building if security/integrity of current location is threatened.

- Emergency Web posting agreement with DIS in the event of DOH server failure.

- If necessary, DOH emergency communications staff—on limited priority basis—can be deployed to affected region (LHJ or Joint Information Center).

Related Support Systems and Materials
- DOH maintains a Bioterrorism Web site with specific links and resources for: General Public; LHJ/Healthcare Providers; and Emergency Responders. (Includes links to information for general public in Spanish.)
- Of 34 LHJs, 29 have Web sites. (Public Health-Seattle & King County has an extensive Web site, with specific bioterrorism resources.) DOH Web maintains map with current links to all LHJ sites.
- DOH has prepared fact sheets on agents of potential bioterrorist threat and emergency planning, and offers LHJs Risk Communication/Media training.
- Listservs: For rapid dissemination of essential materials include – LHJ-HO@listserv.wa.gov (local Health Officers); WACOMDIS@listserv.wa.gov (from Office of Communicable Disease Epidemiology); WSALPHO@listserv.wa.gov (public health system).
- LHJs have relationships with special populations, specific communities, local agencies and organizations within their jurisdictions. DOH will assist—as necessary in evaluating/coordinating public information dissemination.
- List of key LHJ spokespeople identified.

Focus Area F, Critical Capacity A

Work Plan Timeline

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
A-1	Provide coordination for Public Health Emergency Communication / System planning and development	Provide central coordination of related planning and development efforts; provide mentoring/assistance to LHJs and system partners; coordinate related training resources; facilitate communication with emergency mgmt partners	DOH, LHJs, System partners	Hire Public Health System Emergency Communication Manager • In DOH Office of Public Health System Planning and Development	6/1/02
A-1 & A-2	Coordinated system response through Regional Emergency Communications Committees	Provide assessment of and direction for enhancing LHJ and system emergency public health information planning efforts and related resources	DOH, LHJs, System partners	Committees created; meetings scheduled (may be in conjunction with LHJ work group created through Focus Area A[*])	7/1/02
A-1	Provide resources to LHJs and system partners through central source	Work with DOH Office of Public Health Systems Planning and Development, and other system resources to develop and maintain Web-based library of resources and training tools	DOH, LHJs, System partners	Hire System Resource Web Developer • In DOH Web Development Team to work in coordination with related DOH, LHJs and system partners	6/1/02
A-1	Public Health Information Emergency Communication / system support	Emergency Call Center for LHJs and general public; emergency back-up for Communications Office	DOH	Call Center established (in 1101 SE Quince building/Olympia)	5/1/02
A-2	Emergency Public Health Communications Capacity Survey	Assess existing LHJ communications resources (compile library of LHJ emergency communication plans)	DOH, LHJs	Work with combined Focus Area[*] assessment tool; disseminate results	9/15/02
A-3	Create roster of qualified speakers for presentations and response to system staff and general public	Resources drawn from pool of scientific and public information professionals; presentations geared toward target populations; resources for system staff	DOH, LHJs, System partners	Create directory of resources • Contractor(s) hired to develop presentation materials, as necessary	9/1/02 and ongoing

---

[*] Focus Area Integration

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
A-3	Develop resources for general public and special populations	Working with Regional Emergency Communications Committees, plan and develop platform of resources for education and outreach to general public/special populations. Prioritize needs in tiered development structure.	DOH, LHJs, System partners	Input from regional committees; platform of necessary resources outlined; LHJ and resource needs prioritized • Regional/centralized contractors or staff hired • 1st tier resources developed & disseminated	8/1/02 through 7/30/03
A-4	Provide risk communication/ media/issues training	Working with Regional Emergency Communications Committees, LHJs and related offices, plan agenda of necessary trainings; develop curriculum in variety of formats	DOH, LHJs, System partners	Develop list of priority training needs Plan/implement regional training sessions Develop and implement plan to expand existing training resources Identify additional training needs	8/1/02 through 7/30/03

Budget Narrative, Focus Area F

Salaries	179,732.
Benefits	43,136.
Travel	18,750.
Equipment	0
Contractual	626,824.
Supplies	27,540.
Other	55,900.
Sub-Total	951,882.
Indirect costs	76,759.
Total	1,028,641.

Salaries...$179,732.

Department of Health

- System Emergency Communications Manager (DOH, 1FTE, WMS2 @ $5,266/month x 15.5 months = $81,623 salary)

- System Web Developer (DOH, 1FTE, PIO3 level @ $4322/month x 15.5 months = $66,991 salary)

- Bioterrorism Response Public Information Officer (continuation of current temporary DOH position- 1 .60, PIO3 level @ $31,118 salary – 12 months)

Benefits...$43,136.

Calculated at 24% of salary total.

Travel...$18,750.

- $13,950 for System Emergency Communications Manager (per diem and estimated mileage/fares based on statewide travel 7 days per month/15.5 months)

- Estimate of $100/month mileage for 2 other DOH FT positions = $2,400/annually.

- DOH staff attendance at 4 system emergency communication committee meetings @ $600/ea x 4 = $2,400/yr.

Equipment ....$ 0.

- No equipment estimates.

Contracts...$626,824.

Administered through Department of Health: $195,000.

- Curriculum development/trainer fees = $40,000

- Materials development for general public, special populations, public health system staff, etc. (estimate including writers, editors, graphic designers, PowerPoint presentation development, video services, translators, etc.) = $75,000.

- Educational materials printing = $80,000

Administered through Local Health Jurisdictions: $431,824.

- Western Region Bioterrorism Communications Coordinator or related position (based at Seattle/King County, 1FTE @ $5,266/month x 15.5 months = $81,623 salary / benefits @ 24% = $19,589.)

- Eastern Region Bioterrorism Communications Coordinator or related position (based at Spokane County, 1FTE @ $5,266/month x 15.5 months = $81,623 salary / benefits @ 24% = $19,589.)

- For 2 FTEs: computer workstation ($2,500/ea x 2); laptop ($3,500/ea x 2); software ($1050 x 2); supplies ($650 x 2); rent/util/phone/etc. ($14,000/ea x 2) = $43,400.

- Estimated additional computers, fax machines, cellular phones, upgrades, etc: $2,000 x 35 LHJs = $70,000.

- Travel for LHJ participants in regional training and system emergency communication committee meetings:
  - *4 risk communication/media training sessions (from DOH)*
  - *8 risk communication training sessions (resource to be determined)*
  - *4 system emergency communications meetings*
  16 total sessions @ $1,000/ea = $16,000.

- LHJ Staff backfill support for bioterrorism/emergency communication-related training and projects: $10,000 per 10 regions = $100,000

Supplies..**$27,540.**

- Estimated $650 x 2.6 DOH FTEs = $1,690.

- Computer software (estimate based on average mix Office Suite, Web development and/or graphic design software licenses, as necessary): $750 per 2 new DOH workstations / $300 for laptop = $1,850.

- Regional training and system emergency communication committee meetings (for key public health staff):
  - *4 risk communication/media training sessions (from DOH)*
  - *8 risk communication training sessions (resource to be determined)*
  - *4 system emergency communications meetings*
- 16 total sessions @ $1,500/ea (facility, materials, etc.) = $24,000.

Other...**$55,900.**

- Emergency Call Center (serving system): Estimated $250/line x 10 lines = $2,500

- Toll-free emergency phone numbers/related fees = Estimated $500 annually

- DOH Communication Office phone system upgrade (to increase response capacity) = $500

- Computer workstations (2 DOH) @ $2,500 per workstation x 2 = $5,000

- Computer laptop: (1 DOH) = $3,500.

- Estimated additional computers, fax machines, cellular phones, upgrades, etc: $2,500

- Estimated phone, rent/utilities, IS support, employee training for 2.6 FTE ($14,000 x 2.6) = $36,400.

- DOH Staff backfill support for bioterrorism/emerge ncy communication-related training and projects: $5,000.

Indirect based on:
- 21.3% of noncontract costs = $69,237.

- 1.2% of contracts over $20,000 = $7,522.

Total funds requested:…………………………………………………………….$1,028,641

Focus Area G: Education and Training

Current Capacity
The CDC publication, *Bioterrorism and Emergency Public Health Preparedness and Response: A National Public Health Training Plan* (January 11, 2002), lists "design an integrated learning delivery system" as one of the strategic elements that is essential to preparing a competent workforce. The other elements are:
- Monitor workforce composition and identify target audience needs
- Identify required competencies and develop related curriculum
- Use incentives to assure competency (e.g. certification and credentialing)
- Conduct research and evaluation
- Assure financial support, coordination and accountability

The Washington Public Health Improvement Plan (2000) has identified similar elements in its current public health workforce development plan (FY 01-03).

To create an effective delivery system that assures the availability of a prepared, competent workforce to manage public health emergencies (including bioterrorism) requires a comprehensive system addressing all strategic elements listed above. To meet the goals of this cooperative agreement, the system must facilitate several different learning strategies in addition to training, including: collecting, cataloging, and continuously updating lists of best practices and persons with expertise, establishing and coordinating mentoring or peer networks, and maintaining information repositories. The results from existing assessment information[*] have identified Washington's three most pressing needs: human resources, technology, and barriers to participation. This proposal describes how we will address those needs.

Human Resources
The CDC-designated distance learning coordinator role that is shared with the University of Washington (UW) Northwest Center for Public Health Practice[†] (NWCPHP) provides coordination, support, consultation and outreach for the maintenance of a statewide public health distance learning system. The state Emergency Medical Division (EMD) funds a 0.5 FTE for terrorism training and exercises. The state Public Health Lab dedicates 2 FTEs for training having an internal and external focus. While most DOH training covers generic topics related to management and government, a few state and local public health staff have developed and presented limited Bioterrorism (BT)/ Preparedness education and training programs, including tabletop exercises on public health emergencies. Public health training is also conducted at the program level for specific areas such as HIV. LHJs have limited resources for trainers, especially for BT and public health emergencies. Some larger urban jurisdictions have staff with training

---

[*] DOJ/CDC Public Health Performance Assessment for Emergency Preparedness (12/14/01), the CDC – PHPPO DRAFT State Emergency Preparedness and Response Inventory (3/4/02), and three recent focus group meetings with various audiences: Health Education Advisory meeting (2/6/02), Regional Assessment Coordinators (2/25/02), PHIP Workforce Development Committee (2/28/02)

[†] The Northwest Center for Public Health Practice is part of the UW School of Public Health and Community Medicine and also maintains links to the Schools of Medicine and Nursing.

expertise, but the most jurisdictions do not. The regional EMS and Trauma Care Councils provide ongoing education and training by 300 DOH-recognized Senior EMS Instructors to EMTs, paramedics and other health care professionals involved in emergent patient care. Continuing education programs for emergency department physicians and nurses also exist.

Technology

DOH has developed an on-line registration and learning management system to increase local access to PHTN broadcasts through the existing statewide satellite downlink sites. Land-based videoconferencing is available at three DOH sites (Olympia, Seattle, Kent) and one local health district site (Spokane). The sites are able to connect to external systems as well to one another to increase local access but often must use an external bridge for multi-point availability. The NWCPHP has access to the K-20 Network for videoconferencing, which can connect with other K-20 sites at no charge. The Center also has access to a satellite uplink facility at educational transponder rates, listservs, web discussion boards, and its own web site that has been used for piloting some distance learning courses in partnership with DOH.

The strongest, perhaps most utilized technological capacity is the existing extranet between state and local health jurisdictions through the Intergovernmental Network. Although other providers (e.g. health care facilities and managed care organizations) may not be connected to the extranet, they are able to participate in many of the Internet based distance learning opportunities that include listservs and streaming media. The extranet is underutilized as a learning tool, and many offerings are focused on IT related topics. While this appears to be changing, especially within the military system, there are few e-learning courses or other learning applications devoted to topics that address BT/emergency preparedness competencies for public health.

DOH-supported regional and local prehospital and hospital training is conducted statewide using web-based courses as well as traditional classroom settings. This training is coordinated and operates in conjunction with, the community college and university systems, which help provide ongoing teaching, training, and technical support for the systems. The Washington Hospital Association uses web-based applications to deliver training to its members. Some hospitals that have telemedicine technology can use it for learning as well as for clinical consults. The Fire Education Training Network (FETN) as well as the larger Washington cities (Seattle, Tacoma) use closed circuit television systems in addition to traditional settings to provide training within their organizations.

Reducing barriers

DOH sponsored distance training is limited to satellite productions through the CDC PHTN. To encourage participation in PHTN broadcasts DOH pays downlink rental, registration and materials fees. DOH also subsidizes the classroom based Public Health Core Functions training offered to the local/state health workforce three times per year. Some of the professional associations that target the broader audience also provide free or reduced cost access to training resources. Some special events are subsidized to broaden their reach; DOH and NWCPHP are subsidizing a satellite broadcast and half-day training on risk communication.

Determination of Adequacy

Human Resources
The Training Subcommittee of the COT has identified curriculum, training sources and training providers from either state or federal agencies that meet basic training standards. These training opportunities are not tailored to specific audiences and there is no capacity to revise them. COT also identified nearly 100,000 first responders who require weapons of mass destruction awareness level training. There are not enough people to provide this training, nor is there a coordinated training effort, as trainers are spread across different agencies and organizations. The regional EMS and trauma care council system currently supports some basic education and training infrastructure, but current staffing levels, even using a train-the-trainer approach, will not adequately reach the required audience.

Washington has identified state and local public health workforce development standards and measures. There are few dedicated resources or even potential resources at the local level to provide the training and associated tasks of coordination, marketing, instructional design, technological support, and conducting needs assessment, etc. Resources at the state level are also scarce. In many sectors, competency-based needs assessment is not done on a regular basis as part of an integrated performance assessment/appraisal and development plan.

Technology
Washington has many of the distance-based learning technologies needed to deliver a blended approach that meets multiple learning needs and learning styles: satellite broadcasts, videoconference, IP-based streaming media and interactive web sites. But problems exist with interoperability, fragmented administration, conflicting security requirements, and who can access the systems for education. The rapidly changing technical environment presents its own problem of how to keep up on both the server and the client end, especially as we reach across multiple systems, networks, and target populations. A systematic assessment of the gaps in technology capacity is needed to identify and prioritize technology needs to most efficiently manage limited resources. Early results from a distance-learning information technology assessment suggest that access to functional streaming media software might be a problem in the current workforce. An assessment must address user competence, ongoing technical support and maintenance of these systems.

Reducing Barriers
The biggest barrier to participation in learning activities within the public health system is the lack of resources to support individual participation in learning activities. For most of our target audience the costs of traditional off-site training, including registration fees, travel expenses, time off, and loss of revenue are prohibitive. This is especially true in remote rural areas with small hospitals LHJs and EMS agencies which have very limited resources. Travel costs for education and training opportunities outside their local area are prohibitive. DOH subsidies to local entities have traditionally been limited to training or registration, with no support for other costs (wages, travel, and lodging) associated with the training. EMD no longer offers subsidies for its students.

In addition, academically developed training may fail to meet the real needs of the practice community, resulting in another identified non-financial barrier. Traditional course-objective based evaluations usually fail to detect this.

Proposed Improvements

Human Resources

Our primary focus is to leverage existing local, state and federal training and distance learning capacity through investments in local and state staff who will have explicit responsibility to assess needs, coordinate and disseminate existing resources, and direct new resources to areas of greatest need. Additional FTE investments will build:

- Technical expertise to generate graphics to support and augment textual material, convert it to other formats (text only, text with audio, multimedia – and each in various client formats such as QuickTime, RealPlayer, Windows Media Player and support multiple delivery schemes including: videoconference, live broadcast, interactive CDs, and VHS tape.)
- Instructional design expertise to design user-centered learning that incorporates skilled application and integration of adult learning, multiple intelligences theory using various instructional and technological mediums.
- Trainers who have the skills to function in a variety of instructional roles as teachers, mentors, coaches, facilitators, consultants and local distance learning coordinators.

Local Capacity: Most of the staffing investments (10 FTEs) will be made to regional lead agencies using the existing local community assessment coordinators model as a framework. DOH has successfully employed this model to enhance community assessment capacity in local jurisdictions. In this model a full time regional trainer located within the region provides learning support services and works in collaboration with local EMS/trauma and hospital trainers and local public health trainers to assess existing capacity and identify learning needs.

These local/regional assessments will address learning needs to meet selected competencies defined by established standards such as Columbia University's "Core Public Health Worker Competencies for Emergency Preparedness and Response." Competencies for primary care, EMS, and infectious disease will be selected and included. Combining efforts with those in Focus Areas B & E, the regional trainers will collaborate with the NWCPHP, other local content experts (i.e. DOH Office of Communicable Disease Epidemiology, Health Alert Network staff) and additional stakeholders (academic institutions, professional associations, EMD, law enforcement, primary care, tribes etc.) to develop a plan addressing learning and technology needs. The state regional liaison will work with the NWCPHP and regional trainers to identify, assemble and in some cases provide resources to meet these needs.

The local regional trainer and the state regional liaison will be responsible for strengthening coordination and integration between various parts of the emergency response system. The regions (with DOH support) will convene regular regional meetings for trainers to provide opportunities for additional competency building, problem solving and sharing resources. Additional regional activities include providing regional distance learning coordination in

collaboration with the state DLC, and assuming responsibility for providing Core Functions workshops at least once per year. Regional trainers can be located in a wide variety of settings including community colleges and universities, EMS Regional Council Offices, or hospitals with consideration given to possible opportunities to leverage additional resources including adequate training space and building formal relationships. Ideally regional coordinators would possess basic training skills and more advanced skills in instructional design or distance leaning technology

State Capacity: An investment of $235,260 will fund 3.0 FTEs in DOH. One FTE is for a Regional Learning Support Liaison with both training and instructional design expertise to coordinate statewide regional activities, monitor workforce development activities, identify, catalog and disseminate information on existing resources, conduct and coordinate statewide technology and learning needs assessments. One FTE is for a web and database development for Internet learning projects that are most efficiently provided at a statewide level. This might include web-based catalogs of best practices and lists of people with needed expertise, tools for establishing and coordinating mentoring /peer networks and developing repositories of reference materials. Both staff will work with subject matter experts from Focus Areas B and C.[*] A 0.5 FTE is for increasing existing distance learning support to full time to provide technical and operation support for distance learning activities and a 0.5 FTE is to provide administrative and clerical support for the identified 2.5 FTEs

Technology
As a first step DOH will coordinate with regional trainers to administer an assessment of critical technology requirements to support ongoing preparedness learning. This work will be coordinated with Focus Area A, E,[*] and HRSA[†] Assessment activities. Up to $290,000 will be available to implement priority projects identified by the assessment. Priority will be given to assure local access to downlink facilities for emergency broadcasting purposes within 24-48 hours, especially for the Washington State Public Health Laboratories, which also houses the Office of Communicable Disease Epidemiology. (LINK to Focus Areas B & C)

Reducing barriers
A total of $77,000 in learning support funds will be allocated to defray costs associated with travel, tuition etc. The regional trainers will be responsible for administering the support funds and collaborating with local partners to establish criteria for distribution. The regional trainers will also assist in assuring that learning resources meet the competency-based needs of the practice community.

---

[*] Focus Area Integration
[†] CDC – HRSA Coordination

Focus Area G, Benchmark 14

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
14	Develop regional plans to meet learning needs through multiple sources	Participate in assessment development process described in Focus Area A, Section II Benchmark #3, to determine best approach to include learning needs for emergency department personnel, infectious disease specialists, public health staff and other health care providers as part of the second phase.	UW NW Center for PH Preparedness, DOH training liaison, stakeholder committee, assessment development committee, *LINK to HRSA assessment*	Timeline for second phase of assessment focused on learning needs	5/02-6/02
		Develop learning needs assessment process and tools that measure competency strengths, gaps and barriers.	UW NW Center for PH Preparedness, DOH training liaison, assessment development committee	An assessment instrument template and process	9/1/02
			Regions/DOH Liaison	Pilot test in 3 regions	10/30/02
		Implement learning needs assessment		Conduct assessment	1/31/03
		Analyze results	Regions	Identify competency strengths, gaps and barriers Prioritize needs and recommend improvements and ways to build on strengths Incorporate into updated regional educational plans	2/28/03

Focus Area G, Critical Capacity A

Work Plan Timeline

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
A	Increase capacity for public health learning assessment and delivery of multiple learning strategies and methods.	Increase, learner support (e.g. technical support, instructional design) assessment, and training capacity for each region	LHJs	At least 1 trainer identified for each region. Different categories of expertise may be located in different regions and shared across them. 1 DOH Training Liaison with instructional design expertise to convene network meetings, establish peer support and mentoring process, provide technical assistance to regions	6/1/02
				1 DOH web/database developer to increase state/local e-learning capacity and technical assistance	
	Assess existing capacity across sectors to conduct assessment, planning, and provide access to multiple learning strategies.	Collaborate with Focus Area A assessment activities to incorporate learning capacity assessment into system capacity planning assessment tool and process	LHJs, Hospitals, EMS regional councils, link to HRSA grant assessment	Assessment tool developed Implement assessment Analyze data results	5/02-6/02 7/02-9/02 9/02
	Develop ongoing plan for meeting learning needs through multiple sources.	Based on existing assessment information (E.g. DOJ) and learning tools, develop initial regional plans to meet learning needs using variety of sources including PHTN, Center for PH Preparedness, other academic institutions (Community Colleges, other state universities) and other organizations (See critical benchmark #14 for timeline)	LHJs, Hospitals, Regional EMS Councils, CME coordinators, Regional EPI, HAN experts	Initial regional education plans developed	7/01/02

Capacity Activities	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		Update plans as data from future assessments of capacity, learning needs and lessons learned from tabletop exercises become available	LHJs, Hospitals, Regional EMS Councils, CME coordinators, Regional EPI, HAN experts	Progress reports and updated regional plans	2/28/03 7/01/03
	Develop technical capacity at the state/local level to provide multiple learning strategies including distance learning.	Increase technical capacity and support to receive satellite broadcasts, provide 2 way video conferencing and provide internet connectivity to view video, and imaging capacity to view live feeds	LHJs, EMS Regional Councils, Hospitals, Educational Facilities	All critical health care staff in local regions and DOH facilities (including the public health lab) able to view emergency satellite broadcasts within 24-48 hours notice Increase existing .5 DOH DL support to full time to increase technical assistance and support for DOH and local regional staff	1/31/03 6/1/02
	Decrease identified barriers to staff participation in learning activities	Increase resources to support costs for staff participation in multiple learning activities	LHJs, EMS Regional Councils/ Hospitals	Distribution plans established for each region	7/31/02
		Decrease travel impacts by providing regional training in core public health skills to program staff	Regions	All regional trainers complete Core Functions Train-The–Trainer workshop	12/31/02

Focus Area G Budget Narrative

	State	Local/Regional	UW/NWCPHP
Salaries	$151,890 (3 FTE)	$588,710 (1 FTE each x 10 Regions)	
Benefits @ 24%	$36,454	$141,290	
Travel	$6,000 ($2,000 x 3 staff people) in-state travel. $15,000 ($5,000 x 3 staff) out-of-state travel to national PHTN Distance Learning Conference	$20,000 ($2,000 each x 10 Regions) in state travel. $50,000 ($5,000 each x 10 Regions) out-of-state travel to national PHTN Distance Learning Conference $77,000 ($7,700 each x 10 Regions) Travel to and tuition scholarships for LHJ staff attendance at trainings.	
Equipment	$140,000 DL equipment – satellite dish, web camera, video conferencing equipment and/or upgrade of existing equipment at state facilities	$150,000 ($15,000 each x 10 Regions) DL equipment – such as satellite dish, web camera, video conferencing equipment, etc	
Contractual			$27,000 to UWSPHCM/NWCPHP for Leadership Institute
Supplies	$17,214 ($5,738 each x 3 FTE) building rent, utilities, phones, info services support, etc. $1,200 ($400 each x 3 FTE) paper, pens, staples, copies, etc.	$125,000 ($12,500 each x 10 Regions) space rent, utilities, phones, info services support, etc. $128,000 ($12,800 each X 10 Regions) paper, pens, staples, copies, easels newsprint pads/markers, desks, projectors, white boards, etc.	
Other	$7,500 ($2,500 each x 3 FTE) computers.	$50,000 ($5000 each X 10 Regions) Computer, software, PDA, etc.	
Sub-Total	$375,258	$1,330,000	$27,000
Indirect costs	@ 21.3 = $79,929	@ 1.2 = $15,960	@ 1.2 = 324
Total: 1,828,471	$455,187	$1,345,960	$27,324

STATE

Salaries

1.0 Distance Learning Liaison (HSC3), $ 4,428/mo X 12 = $53,136
1.0 Web designer (ITSS5), $5,266/mo X12 = $63,192
0.5 Distance Learning support (HSC1), $3,215/mo X12 =$19,290
0.5 Secretary/Administrative Assistant (AA2), $2,712 X 12 = $16,272

Benefits

Calculated at DOH rate of 24% of salary.

Travel

Travel costs estimated at $2,000 per FTE per year x 3 staff for in-state travel

Travel and registration costs estimated at $5,000 per FTE per year x 3 staff for attendance at the national PHTN Distance Learning Conference.

Equipment

Distance learning technology to include purchase or upgrade of existing satellite dish, web camera, videoconferencing equipment at state facilities. Specific equipment to be determined after the capacity assessment is completed.

Supplies

Includes infrastructure support (space rent, telephone, mail services, Information Services chargeback for network, software support, etc.) per DOH formula.

Other supplies include office supplies such as pens, paper, staples and other consumable goods as well as copying, etc.

Other

Includes purchase of computers/software for three (new) staff.

Indirects

Indirect rates for funds retained in agency are calculated at 21.3%.

REGIONAL

Salaries and Benefits

Salaries for regional FTEs are based on $73,000 including benefits @ 24%

Travel

Travel is based on $2,000 per FTE for 10 regional FTEs for in-state travel.

Travel and registration costs estimated at $5,000 per FTE for 10 regional FTEs for attendance at the national PHTN Distance Learning Conference.

Travel to and tuition scholarships for LHJ staff to attend trainings. $7,700 to each of 10 Regions. Each Region will allocate these funds to support LHJ staff attendance at trainings.

Equipment
Distance learning technology which will be further determined after the capacity assessment is completed. May include a combination purchase of satellite dishes at $20,00 each and videoconferencing equipment at $10,000 each, depending on areas of greatest need.

Supplies
Includes infrastructure support (space rent, utilities, phones, information systems maintenance, etc.) to support each regional FTE.

Other supplies include training supplies necessary to start in-house training such as program software, white boards, easels, and overhead projectors, markers, etc.

Other
Includes purchase of computers, software, PDAs, etc. for each regional FTE.

Indirects
Indirect rates for funds passed through to outside agencies are calculated at 1.2%.

UNIVERSITY OF WASHINGTON
Contractual
Includes pass-through monies to the University of Washington for Leadership Institute.

Indirects
Indirect rates for funds passed through to outside agencies are calculated at 1.2%.

Documentation of Local Involvement

Table of Contents

Documentation of Local Involvement in Planning for Bioterrorism Response in Washington State

Overview

Washington State's public health system is a partnership of state and local health agencies. The state provides certain direct services (vital records, public health lab, professional licensing, drinking water safety) and the 34 local health jurisdictions provide the remainder or act as a state service outlet.

Washington State's planning approach is predicated on an assumption that *local* preparation is essential for an effective response to bioterrorism or other public health emergencies. Our statewide plan will incorporate priorities set by local communities as well as among groups of communities within a shared region.

Chronology

Our grant preparation process relied on frequent, active participation with local partners, using both formal and informal communication. A chronology of the significant events:

February 5, 2002: A meeting was held with the Secretary of Health, the Chair of the Washington State Association of Local Public Health Officials (WSALPHO) and other representatives of the association and the Secretary's office to discuss basic approaches to the grant. Agreements were made that every planning committee would have local health participants, that these people would be formally appointed by WSALPHO and would represent the Association, rather than their individual district. In addition, there was general agreement that resources needed to be used most efficiently and that regional approaches would be important. One local member, Pat Libbey, was appointed as official liaison to the Department of Health (DOH) for this subject.

February 7, 2002: The Secretary and WSALPHO Representative presented an overview of the Bioterrorism grant to health officials from throughout the state and discussed basic approaches.

February 12: Department and WSALPHO representatives met to begin to draft local and regional approaches, later shared and discussed in a variety of meetings.

February 20: WSALPHO Chair and Liaison met with DOH planning team to select potential participants to be invited to members to participate in each aspect of grant preparation. Members were recruited in the following days, generally two to three members per team for a range of local perspectives.

February 25 to date: Six teams met and exchanged email documents outlining approaches to each focus area of the grant. Each team included a number of appointed local health and hospital personnel.

March 11: A meeting was held among WSALPHO representatives to jointly develop a set of guiding principles (attached) and to outline the preferred approach to funding of regional services.

March 20, 21, 22: In two half day meetings, plus a two hour final meeting, WSALPHO representatives, a hospital representative, and DOH grant team members met to outline the entire proposal. These meetings provided an opportunity to adjust plans and identify points of coordination and integration of effort needed throughout the planning and implementation cycle.

March 20: the WSALPHO Chair sent a general message to all members outlining the approach developed through involvement by the association. A detailed message from the Secretary was sent to all local health officials, via email, explaining the approach adopted jointly by DOH and WSALPHO and describing the initial funding and expectations for local-level preparedness.

March 27: Executive summaries from both HRSA and CDC proposals and LHJ allocations and funding summaries were sent as attachments to a memo from the Secretary to all local health officials, LHJs, hospital partners and proposal committee members as information. Included was an invitation for partners to request the draft proposals for review.

Future Continued Coordination: In addition to the required advisory committee, an ongoing management group will be formed. This will include local health representation from the association as well as local health regional coordinators for this grant, and DOH and hospital members. This group will meet more frequently than the advisory group and attend to operational issues as well as provide for statewide coordination for local and regional activities.

Attachments
1. Jointly adopted Goals and Principles for Public Health Preparedness and Response Planning Project.

2. List of local health members involved in application development teams.

3. Message via electronic mail from Washington State Association of Local Public Health Officials (WSALPHO) leadership to general membership, 3/20/02.

4. Regional Planning Framework document sent to WSALPHO membership by Sec. Selecky on 3/20/02.

5. Memo and attachments from Secretary Selecky to local health, hospital partners and proposal committee members.

6. Budget worksheet related to funding distribution with local health jurisdictions.

Attachment 1:
Goals and Principles for Public Health Preparedness and Response Planning Project

Goals

As part of a national effort, Washington's public health officials will create a public health system that is better prepared to respond to emergencies and public health threats. This matter is urgent and requires swift action.

We will identify gaps and take action to strengthen the public health infrastructure at local, regional and state levels.

We will demonstrate that we have improved our ability to address critical capacities and benchmarks set forth by the federal government.

Guiding Principles

State and local health leadership jointly adopted the following guiding principles. These principles will direct the work plans and actions called for in the Centers for Disease Control Cooperative Agreement for Public Health Preparedness and Response Planning.

Capacity needed at all levels
1. Preparedness must extend to all people who live in our state. Capacity for establishing and maintaining preparedness should be developed at all levels of government: local, regional and state.

Communication
2. Continuous, two-way communication is essential between local and state health offices and will be maintained throughout the process of improving emergency preparedness.

3. The Department will establish a state-local project oversight group to monitor project timelines and accomplishments, to assure efficient use of resources and avoid duplication. Participants will include Department staff, plus local health and hospital representatives. This group will meet more frequently and be more engaged in the details of the planning effort than the State Advisory Committee called for by CDC.

Assessment, Planning and Action
4. Assessment efforts will employ standard tools across the state so that we can build regional and state plans based on common data, and so that we will have comparable information in the future.

5. High priority issues may be identified before a comprehensive statewide assessment is completed. Some of these needs may be addressed immediately, if they are based on prior

assessments. However, it is expected that the state and regional work plans will be built on assessment efforts and all investments tied to clearly demonstrated needs.

6. The initial grant application will not be a perfect document, and should be considered a preliminary planning tool. We expect to make adjustments to best meet the needs demonstrated statewide through assessment and experience gained.

7. Teams developing initial work plans for the grant application should use all available information but should not attempt to predict assessment outcomes or the appropriate capacity of regions. Instead, they should seek to define parameters, describe levels of performance expected, note coordination needs and make links to benchmarks.

8. There must be demonstrated accountability to enhanced preparedness through addition of new federal resources, but we encourage multiple uses of these new personnel and assets in order to strengthen the whole public health system.

Local
9. The impact of any event is felt first at the local level. Every local health jurisdiction, to be prepared for emergencies, must assess local needs and develop a written response plan. Funding is needed to support this effort.

10. LHJs are expected to exercise leadership in planning coordination. Local plans must be coordinated with local hospitals, emergency management services, and other emergency responders. Plans must be tested locally, across these sectors and should be included in local EMD plans (ESF 8.)

11. While local plans will be unique, they will be built on standard assessment tools. Local plans are expected to "roll up" to help create regional plans.

12. The basic planning framework desired is locally driven. The state work plan should not restrict local planning through excessive directives, but let proven needs guide local plans.

Regional
13. Regional effort is important because there is not sufficient resource to meet needs at every local level. Coordination within regions is essential to reduce unnecessary duplication of effort and encourage sharing of resources.

14. Regional capacity and regional needs vary based on the region's complexity, previous efforts in emergency preparedness, size, assets, geographic location, and proximity to borders.

15. Regional resources will be provided and used to boost capacity across regions. Staff will be based in local lead health jurisdictions. Regional offices will serve to a) set priorities, b) develop mutual aid agreements within and between regions, and c) provide assistance to each local jurisdiction in the area. Regional staff will coordinate efforts with the state offices and between regions; expectations for coordination also apply to single county regions.

16. Regional efforts will be provided funds from the initial allotment for this grant. Additional funding will follow based on needs and plans that result from assessment findings. Initial regional and local funding is not a guarantee of future fund allocations.

17. Regional plans will incorporate local plans and regional plans will "roll-up" to provide the basis for the state plan.

State

18. The state Department of Health (DOH) has responsibility to ensure that grant requirements are met and will serve as primary contact with granting agencies.

19. State capacity will be built for areas that require statewide effort and for coordination to ensure integrated planning. DOH will provide a structure and process to create coordinated planning, and will provide direct assistance to regions.

20. The overall state plan will incorporate local, regional and state plans for improved emergency response, assuring that implementation activities are consistent with locally demonstrated needs.

Attachment 2:
Local Health members involved in Bioterrorism Planning Team meetings:

Ward Hinds, MD, Chair, Washington State Association of Local Public Health Officials and
      Health Officer, Snohomish County
Pat Libbey, Director, Thurston County Health and Human Services Department and
      WSALPHO BT Liaison
Alonzo Plough, PhD, Director, Public Health Seattle-King County
Jeff Duchin, MD, Chief of Epidemiology, Public Health Seattle-King County
Federico Cruz, MD, Director of Health, Tacoma-Pierce County Health Department
Lori Albert, RN, Administrator, Okanogan Health District
Bill Estrom, Bioterrorism Coordinator, Spokane Regional Health District
Karen Crouse, Lab, Vital Records Director, Spokane Regional Health District
Paul Swenson,
Scott Lindquist, MD, Health Officer, Bremerton-Kitsap County Health District
Diana Yu, MD, Health Officer, Thurston County Health and Social Services Department
Torney Smith, Administrator, Spokane Regional Health District
Sherri McDonald, RN, Deputy Director, Thurston County Health and Social Services
Department
Peter Browning, Director, Skagit County Department of Health
Caren Adams,
Sandy Owen, RN, Nursing Director, Benton-Franklin Health District
Shareefa Abdulla, Communications Director, Southwest Washington Health District
Nancy Goodloe, EdD, Administrator, Kittitas County Health Department
Susan Lybarger, RN, Director Epidemiology, Infectious disease, Southwest Washington Health
District
Kim Thorburn, MD, Health Officer, Spokane Regional Health District
Larry Jecha, MD, health Officer, Benton-Franklin Health District
Tom Locke, MD, Health Officer, Clallam County Department of Health and Human Services

Attachment 3:

General message from Washington State Association of Local Public Health Officials (WSALPHO) Chair, Ward Hinds, MD, to all members, March 20, 2002:

Overview

The federal guidelines for public health bio-terrorism preparedness and capacity building were received from CDC in the latter half of February. The federal guidelines addressing hospital preparedness were received from HRSA earlier in February. Both guidelines and the expectations they set affect local public health departments. The guidelines obligate the State Department of Health to prepare applications describing how we will go about improving Washington's public health and hospitals preparedness and capacities. The applications must demonstrate "meaningful collaboration" between local public health agencies and the state. The applications must be signed off by the Governor and forwarded to the Secretary of Health and Human Services by April 15, 2002. It's important to note that the applications need not be a complete statement of priorities and action steps leading to improved capacity and preparedness but rather a description of how we will go about setting those priorities and action steps. Most often, the guidelines call for a "timeline" for the development of plans, systems etc.

Since the receipt of the guidelines WSALPHO leadership has been directly involved with the State Department of Health in plan development. WSALPHO intends to assure that the intended improvement in preparedness and increased capacity envisioned as a result of the new funds occurs first and foremost in ways that directly improve and increase the capabilities of local public health to respond to "bio-terrorism, other infectious disease outbreaks and other public health threats and emergencies." In our interactions with the state we have consistently conveyed two key messages for the development of the State's applications. First, it is WSALPHO's position throughout this process that detection and at least initial response to any such events occur primarily at the local level and that this primacy of local detection and response must be reflected in the State's application. And second, that plans and priorities deriving from the applications must be built from the local level up. That is, local and regional preparedness needs are the primary driver of the State's approach. It follows then from these two messages, that a very significant amount of the resources needs to be allocated at the local level and improved capacity must be measured primarily in increased resources – staff and otherwise – at the local level. In the main, increased consultation and technical assistance to local public health agencies does not really constitute increased capacity to detect and respond. In addition we have been successful in assuring that local hospital planning has to be done in coordination with local public health and that local public health is the linking means for connecting hospital planning to local emergency management.

The guidelines describe "focus areas" that must be addressed in the application. They describe "critical capacities" that must be achieved in all of the focus areas, as well as "enhanced capacities" that may be addressed in the focus areas when the "critical capacities" have been addressed. The focus areas are as follows:

1. Preparedness Planning and Readiness Assessment
2. Surveillance and Epidemiology Capacity
3. Laboratory Capacity – Biologic Agents
4. Laboratory Capacity – Chemical Agents
5. Health Alert Network/Communications and Information Technology
6. Communicating Health Risks and Health Information Dissemination
7. Education and Training.

As part of preparing the State's application work teams in each of the above areas have been formed. (Note – the two laboratory capacities have been combined in a single laboratory work group.) There are also two additional work groups, one for Hospital Planning and one for rules and Regulations. Multiple local health department staff are serving on each of the work groups along with state and in some cases private sector and other staff. The purpose of these workgroups is to prepare the preliminary timeline, benchmarks, and a gross budget approximation for the particular focus area. Recognizing that priorities are to be a reflection of local need, the workgroups are not tasked with developing statewide priorities (for the most part – recognizing that laboratory capacity and aspects of Health Alert Network may be different). This work is at or near completion.

Beginning the week of March 18th, work has begun to merge the individual focus area work into a single coordinated approach forming the basis of the State application. The various benchmarks will be reviewed and changed as necessary to assure compatibility, timelines will be synchronized and a comprehensive budget will be rolled up from the focus area work groups. WSALPHO members will participate in this work along with state health department staff and hospital representatives.

Later in the week there will be a policy level review of the work and product to date. The purpose of the policy level review is to ensure the federal guidelines are being addressed, that gaps in focus areas are clearly identified, that timelines between focus areas are complimentary, and that the focus area budgets are appropriate and within the federal funds available. The policy review process will also describe the basic organizational framework for implementation of the work plan. Again, WSALPHO leadership will participate in this effort with state health staff, hospital representatives and staff from the Governor's Office/OFM. The final product of this effort will be made available for external stakeholder review and comment and then must be reviewed by the State Emergency Committee on Terrorism before being forwarded to the Governor for signoff prior to April 15th.

Attachment 4

March 20, 2001

TO: Local Public Health Officials

FROM: Mary C. Selecky, Secretary

SUBJECT: Improving Public Health Preparedness for Bioterrorism and other Public Health Emergencies; New Federal Funding

This memo is the follow up to an earlier notice from Ward Hines regarding the plan for improving our preparedness and response to public health emergencies.

In response to the events of September 11, 2001 and the later Anthrax attacks, Congress provided significant funding to strengthen the public health system in our nation. An appropriation of $1 billion has been added to the Public Health Threats and Emergencies Act. That act was originally passed without funding in 2000, as part of a strategy to improve our public health infrastructure. Given the events of the past year, Congress chose to provide funding specifically to improving public health preparedness.

This is the first appropriation in what is anticipated to be continuing funding in the next federal budget cycle and beyond. Each state will receive $5 million, plus additional funds based on population. Washington State will receive $20.6 million. Of this amount, $18.1 is for improving capacity of the public health system between now and August 2003; $2.5 million is specifically for hospital planning between now and March 2004.

Specific Focus Areas and Critical Capacities
To guide investments in improving preparedness, appropriations are made to the states in specific focus areas. Within each area, there are some "critical capacities" and "critical benchmarks" that require attention, and "enhanced capacities" that can be supported when critical capacities have been addressed.

The grant application must be organized around these six focus areas:
- Preparedness Planning and Readiness Assessment
- Surveillance and Epidemiology Capacity

179

- Laboratory Capacity
- Health Alert Network
- Risk Communication and Health Information Dissemination
- Education and Training

Swift action and local involvement are expected

Federal officials have made it very clear that improving preparedness is an urgent national security issue. Funds are being made available very swiftly and grant application timelines are short, all in an effort to get needed work underway as soon as possible. While the process for creating state plans will be very fast, it will also be characterized by active involvement from local public health and hospitals.

The initial Washington State grant application will be submitted by April 15. Representatives selected by the Washington State Association of Local Public Health officials (WSALPHO) and the Washington State Hospital Association are actively involved in preparation and review of this application and will maintain ongoing roles.

Our grant application, to be submitted by April 15, will focus on general agreement about timelines and objectives for the intense work that will follow during the coming year. No one expects that our state will know all the important goals, needs and costs at the outset. Instead, federal officials expect that we will address critical needs right away, that we will create an excellent planning process to identify gaps and determine further actions needed, and that we will be able demonstrate clear improvement in preparedness within the year.

Expectations for Local Health Jurisdictions in Washington

Our recommended approach is detailed in the following pages. It is predicated on an assumption that local preparation is essential for an effective response to bioterrorism or other public health emergencies.

Every local health jurisdiction will be provided funds and asked to develop a written bioterrorism/ emergency response plan, consistent with the resources and needs established for their county or counties. These plans are expected to become part of the local emergency services plan (ESF-8.)

A standard assessment will be part of the planning work and it is expected that a range of community partners will be engaged in the process. While every local plan will be unique, templates and guides for conducting assessments will be provided. Local partners are also expected to participate in the preparation of regional plans.

Funds will be provided quickly

We have received an initial allotment of funds from the federal government, 20% of our grant total. The remaining funds will be made available to the Department after Health and Human Services approves our work plan.

Most of the initial funding is going to LHJs to help gear up for assessment and planning. We will distribute funds to local health jurisdictions as outlined in the following pages, using an amendment to the consolidated contract with each local health jurisdiction. Here is how we expect to proceed: We will first send a notice of award by letter and ask for your response. You may begin billing for these funds from the date specified in that letter. We expect this to happen before April 15.

Regional Resources will be established across Washington
Regional offices will be established in lead health jurisdictions for groups of three to five counties. The proposed regions are based on those used for Emergency Medical Services Councils, but with some shifts among counties.

If you believe your county should be aligned differently than is shown, please contact us.

The regional offices will be expected to provide technical assistance to counties for assessment and planning. They will have capacity for some of the six focus areas addressed in the grant. Regional offices will be asked to convene meetings of partners from throughout the region, in order to identify gaps and strengths within the region, establish mutual aid agreements, set priorities for action from a regional perspective and document progress in improving preparedness over time.

Principles guiding our approach
Close coordination among the partners who protect public health is absolutely vital during an emergency. Our planning process will reflect the partnership that is essential to maintaining coordination. The attached set of principles has been set forth by local and state health officials to guide us in this process.

Questions?
Please call with any questions about the bioterrorism grant, or local or regional roles.

At Department of Health, please direct comments to either Joan Brewster, Director, Public Health Systems Planning and Development (360) 236-4062 or joan.brewster@doh.wa.gov or to Bill White, Assistant Secretary on special assignment (360) 236-4034 or bill.white@doh.wa.gov

I also encourage you to contact the members of your association who have been most directly involved with this effort: Pat Libbey, the designated contact on bioterrorism planning, or Ward Hinds, Chair, WSALPHO.

Attachments:

Page 4:   Key Points for Bioterrorism Planning Approach

Page 6:   Proposed Regions

Page 7:   Proposed Lead Counties and Funding Amounts

Page 9:   Goals and Principles

Key Points for Bioterrorism Planning Approach

The purpose of this funding is to upgrade state and local public health jurisdictions' preparedness for response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies.

Washington State will build a reliable system for response to bioterrorism through careful preparation at both the local and regional level. Our statewide plan will incorporate priorities set by local communities as well as among groups of communities within a shared region. In addition, the statewide plan will address needs that are best planned for from a more centralized or state-level perspective.

Local health jurisdictions (LHJs) will play a key leadership role in creating bioterrorism response plans in collaboration with their existing emergency management and medical response systems. In the event of a bioterrorist attack, LHJs are expected to exercise significant authority and provide expertise that is unavailable from any other sector of government.

Local Health Departments Will Receive Resources for Assessment and Planning

1. Funds will go to every local health jurisdiction to assist in doing an assessment and preparing a *written local plan* for response to bioterrorism and other public health emergencies. Funds will be sufficient to provide for significant staff time.

2. The local plan will become part of the local ESF-8 plan, the health portion of the countywide emergency response plan. While LHJs are in the lead to do the assessment and develop a plan, there will be close coordination with emergency management divisions and other partners in each county.

3. The funds provided *initially* will be to facilitate accomplishing the assessment in order to establish a statewide baseline of current capacity and need. Additional funds may be allocated depending upon assessment results and priorities selected.

4. Each LHJ plan will be unique to that jurisdiction. However, the plan will be completed using standard assessment tools (as a basis) and within timeframes that assure completion of regional and statewide plans in a timely manner.

5. The amount of funding available initially is graduated by size of county, but is geared to resources needed to do an assessment and develop a written plan in every county. This allocation does not represent a model for future allocations. Additional funds will be based upon prioritized need, examined on a regional basis, and availability of funds.

Regional Capacity Will Be Established for Coordination and Regional Response

1. Regional lead health departments will be designated and provided funds to support regional plan development. Funds will be sufficient to hire staff to carry out regional responsibilities. This will augment the county-specific staffing funds.

2. Regional staff will assist smaller counties in carrying out assessments, coordinating planning efforts, and sharing tools and information based on other counties' experience or information from the state.

3. Regional staff will convene meetings of partners, including hospitals and health providers, to synthesize assessment findings and determine priorities for plan development and use of any additional resources, and to develop mutual aid/coordinated response plans. Regional lead health departments are expected to work collaboratively with the regional and local EMS and Trauma Care Councils.

4. Regional staff will work with state Department of Health (DOH) offices to coordinate efforts, share experiences, and to help develop and use standard tools, where deemed necessary.

State Capacity Will Be Established in Accordance with CDC Planning Requirements

1. DOH will designate a senior public health official to serve as the lead coordinator responsible for developing and implementing all activities associated with this cooperative agreement.

2. DOH will hire staff to develop a detailed state response plan, enhance workforce readiness, coordinate statewide preparedness planning, provide technical assistance to LHJs and the medical community, and participate in regional meetings.

3. DOH will work with the Emergency Management Division of the state Military Department to assess communications systems and strategies with the aim of enhancing reliability, redundancy (where necessary), and integration with the emergency alert, notification, and response systems.

4. DOH will work with LHJs, hospitals, the medical community, and other emergency management partners to facilitate the development and exercise of integrated plans that are intended to improve the delivery of critical health services and effective medical management in emergencies.

5. DOH, in its role as state lead agency for Emergency Support Function #8, *Health and Medical Services,* will continue to operate in the existing multi-agency command structure established under the state's comprehensive emergency management plan.

6. DOH will develop drill and exercise plans, at least on an annual basis, to demonstrate proficiency in responding to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies. DOH will also provide technical assistance to the regions to do the same.

Proposed Regions for Biorterrorism Planning
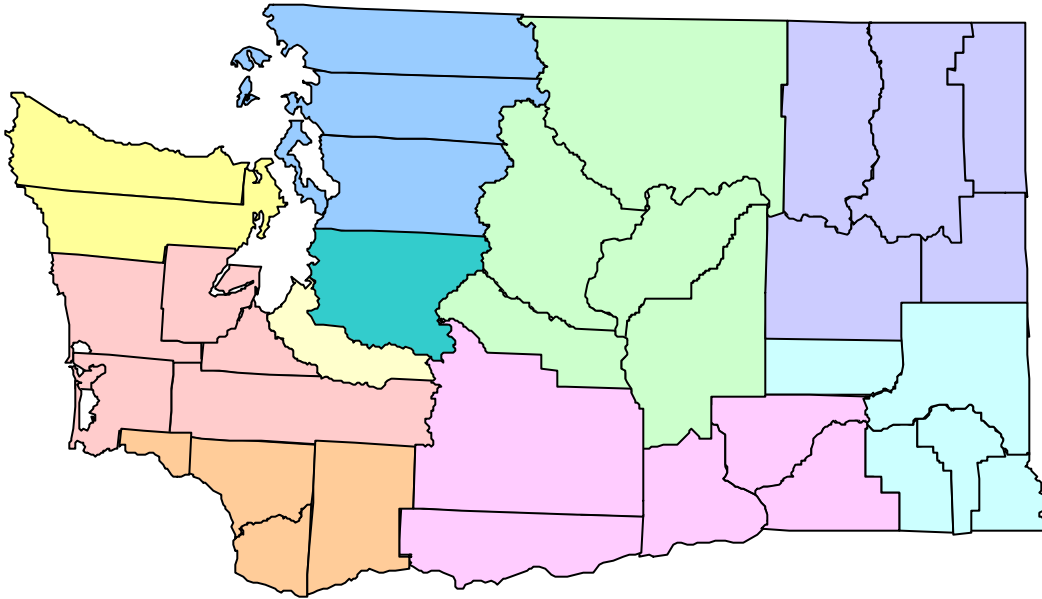
Local Health Regions for Bioterrorism Planning and Coordination

This uses EMS Regions as a basis for regions, but proposes changing some counties. The counties themselves should evaluate each change. Suggested criterion: In a public health emergency, which larger public health department are you most likely to turn to for assistance?

Changes from EMS Regions

Mason is grouped with Thurston, because they have been part of a five county planning region for other purposes.

Pierce is a "region" by itself (King is a "region" now in the EMS scheme).

Kittitas is grouped with Chelan-Douglas instead of Yakima and Benton-Franklin.

Klickitat is grouped with Benton-Franklin.

Columbia is grouped with Whitman/Spokane because of the Southeast Partnership.

Yakima stays in the same EMS region but is not the lead. It has greater population than Benton-Franklin, but does not have a full-time Health Officer.

Other Notes

Spokane is considered two regions, North and South, but serves as the lead county to both areas.

Pierce, King, and Snohomish Counties are expected to coordinate in the Puget Sound core so that we can demonstrate coordinated planning among our most densely populated areas. Snohomish still serves as the lead county for its EMS region counties.

These are **Propose Regions**: If you believe your county should be aligned differently than is shown, please contact us.

CDC Public Health Preparedness and Response for Bioterrorism Resource Management

Lead and Counties	A LHJ Planning	A Regional Planning	B EPI/ Surveillance	C Lab	E HAN	F Communication/ Public Information	G Training/ Education	TOTAL
Bremerton-Kitsap	$75,000	$100,000	$230,000		$8,000		$135,000	$548,000
Clallam	50,000				15,000			65,000
Jefferson	25,000							25,000
Thurston	75,000	100,000	235,000		8,000		135,000	553,000
Lewis	50,000				15,000			65,000
Pacific	25,000							25,000
Grays Harbor	50,000				15,000			65,000
Mason	50,000							50,000
Southwest	125,000	100,000	235,000		8,000		135,000	603,000
Cowlitz	50,000		55,000		15,000			120,000
Wahkiakum	25,000							25,000
Pierce	325,000		355,000		8,000		135,000	823,000
King	550,000		682,500	100,000	8,000	83,500	135,000	1,559,000
Snohomish	150,000	100,000	365,000		8,000		135,000	758,000
Skagit	75,000		55,000					130,000
Whatcom	75,000		55,000					130,000
Island	50,000				15,000			65,000
San Juan	25,000							25,000
Chelan-Douglas	75,000	100,000	227,000		38,000*		135,000	575,000
Okanogan	25,000							25,000
Grant	50,000				15,000			65,000
Kittitas	25,000							25,000
Benton-Franklin	125,000	100,000	350,000		8,000		135,000	718,000
Walla Walla	50,000							50,000
Yakima	75,000							75,000
Klickitat	25,000							25,000
Spokane – North	100,000	100,000	240,000	167,500	8,000	83,500	135,000	834,000
NE Tri	75,000				τ15,000			90,000
Lincoln	25,000							25,000
Spokane – South		100,000	113,000		8,000		135,000	356,000
Whitman	25,000		55,000		15,000			95,000
Garfield	25,000							25,000
Columbia	25,000							25,000
Adams	25,000							25,000
Asotin	25,000							25,000
Total $	2,625,000	800,000	3,252,500	267,500	230,000	167,000	1,350,000	$8,692,000

*15,000 Douglas

τ 15,000 Stevens

Funding Assumptions

Resources are expected to cover staff time plus meeting costs within the county. These are only the resources provided for assessment and local plan development, plus coordination of regional plans. Additional funds may be provided for specific aspects of the plan, depending on assessed needs.

Funds To LHJs
$25,000 to counties under 49,000*
$50,000 to counties between 49,000 and 100,000*
$75,000 to counties between 100,001 and 250,000
$100,000 to counties between 250,001 and 500,000
$150,000 to counties above 500,001

*Counties under 50,000 population are encouraged to combine resources within a region or with another county to carry out planning efforts. Counties between 50,000 and 100,000 may also wish to combine resources.

Funds to Regions
Resources are expected to cover staff coordinator time plus support for regional meetings. The lead county will receive these resources and may use them in combination with county-specific funding in order to carry out both local and regional tasks.

Time Period
For use by August 2003. Additional resources are expected to be provided for related activities during this time period.

Attachment 5

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1112 SE Quince Street ● PO Box 47890 ● Olympia, Washington 98504-7890
Tel: (360) 236-4010 ● FAX: (360) 586-7424 ● TDD Relay Service: 1-800-833-6388

From: Selecky, Mary
Sent: Wednesday, March 27, 2002 4:54 PM
To: 'wsalpho@listserv.wa.gov'
Subject: HHS/CDC Bioterrorism Work Plan Proposal

Since mid-February the Department of Health, working with a number of significant partners including local health, hospitals, emergency response agencies and health care providers, has been developing a work plan to submit to Health and Human Services to address this state's preparedness for a bioterrorism event. We began by seeking out our key partners, both public and private, and we have kept them involved through out the planning process reflected in the work plan.

Executive summary of Work Plan attached
The executive summary of the work plan, attached, represents the combined efforts of many people. Truly, this has been an incredible example of collaboration and inclusion. This document describes the major products and efforts we will initiate when the HHS award is received. If you would like the entire work plan (approximately 150 pages) or any specific focus area, please contact us and we will provide you a copy as quickly as possible.

Questions or comments should be addressed to the project management staff: Bill White at 360.236.4034, bill.white@doh.wa.gov or John Erickson at 360.236-4033, john.erickson@doh.wa.gov .

Thanks to local health partners
As I shared with you in a letter last week, we are committed to the principle that this state's preparedness and an adequate response begin with local capacity. It will be the local hospital, emergency room physician, or clinician that will first see and identify an infectious agent. It will be local public health that will be the first responder to investigate the source and origin of the disease, provide guidance on containment, and communicate to worried residents.

I am grateful that so many local public health professionals took the time to work on this, with very short notice and quick turn-around for document reviews. We could not have met our goals

188

without their help. My special thanks to everyone listed on the following pages and to Ward Hinds, WSALPHO Chair and to Pat Libbey, who agreed to act as a liaison on this topic on behalf of WSALPHO. All of these people put in extraordinary hours and provided essential guidance in this plan.

Funding distributed to local, regional and state functions

This plan provides funding for every local health jurisdiction and every hospital to participate in this effort. To ensure integrated planning and the most efficient use of resources, we are providing funding for regional offices within nine local public health jurisdictions. There will be coordination among and between these regions, creating a strong network of agencies prepared for a range of possible emergencies.

Finally, funding is provided for required statewide capacity so that communities can be assured of adequate support for state-level services. We will ensure that statewide capacity is developed and maintained. Communication between providers and investigators will need to be swift, secure and statewide. The infectious agent would be DNA fingerprinted at the State Public Health Laboratories, and our findings will be forwarded to national partners and neighboring states using secure information technology. Our ability to communicate effectively with all local jurisdictions and to provide support is an essential aspect of our public health "system".

The attached matrixes describe how we expect to allocate funding according to the framework set forth by Health and Human Services. One matrix shows how funds are expected to be spread by grant "Focus Area" among local, state and contracted efforts. The second matrix shows how funds will be allocated among health jurisdictions and regional offices. These are draft figures and are subject to change as we move through a process that requires approval at the state and federal levels. This is the first round of federal funding for public health preparedness, and we fully expect future funding to help address unmet needs determined during this assessment and planning phase.

Expect more information in the weeks ahead

This is an exciting opportunity for public health, but it is also a daunting responsibility and it is unfolding at a rapid pace. I urge your patience and invite your questions, which are very helpful.

We will be forwarding more detailed information in the weeks ahead and we will plan telephone conferences to "check in" along the way. In those letters and calls, we will address regional roles, local responsibilities for planning, contract amendments, and timelines. We expect to provide templates and training for assessment and planning documents so that all the work we do is efficient and well coordinated. The continued contribution of local health expertise will be necessary to create those tools.

For questions about this part of our work, please contact Joan Brewster, (360) 236-4062 or joan.Brewster@doh.wa.gov .

For now, please be assured that you need not take any specific action. In the coming weeks and months, however, we will all be engaged in a very dynamic process. I am excited to look ahead and think about how much better prepared we will be to help our communities respond to

emergencies and unexpected threats. Thank you, in advance, to everyone undertaking this important work.

Attachments
1. Executive Summary of work plan
2. Planning committee participants from local health agencies
3. Funding summaries

Local Health Members Involved in Bioterrorism Planning Team Meetings

Ward Hinds, MD, Chair, Washington State Association of Local Public Health Officials and
        Health Officer, Snohomish County
Pat Libbey, Director, Thurston County Health and Human Services Department and
        WSALPHO BT Liaison
Alonzo Plough, PhD, Director, Public Health Seattle-King County
Jeff Duchin, MD, Chief of Epidemiology, Public Health Seattle-King County
Federico Cruz, MD, Director of Health, Tacoma-Pierce County Health Department
Lori Albert, RN, Administrator, Okanogan Health District
Bill Estrom, Bioterrorism Coordinator, Spokane Regional Health District
Karen Crouse, Lab, Vital Records Director, Spokane Regional Health District
Paul Swenson, PhD, Laboratory Director, Public Health Seattle-King County
Scott Lindquist, MD, Health Officer, Bremerton-Kitsap County Health District
Diana Yu, MD, Health Officer, Thurston County Health and Social Services Department
Torney Smith, Administrator, Spokane Regional Health District
Sherri McDonald, RN, Deputy Director, Thurston County Health and Social Services
Department
Peter Browning, Director, Skagit County Department of Health
Caren Adams, South Region Health Educator, Public Health Seattle-King County
Sandy Owen, RN, Nursing Director, Benton-Franklin Health District
Shareefa Abdulla, Communications Director, Southwest Washington Health District
Nancy Goodloe, EdD, Administrator, Kittitas County Health Department
Susan Lybarger, RN, Director Epidemiology, Southwest Washington Health District
Kim Thorburn, MD, Health Officer, Spokane Regional Health District
Larry Jecha, MD, health Officer, Benton-Franklin Health District
Tom Locke, MD, Health Officer, Clallam County Department of Health and Human Services

Mary C. Selecky
Secretary
(360) 236-4030
(360) 586-7424 FAX
PO Box 47890
Olympia WA 98504-7890
mary.selecky@doh.wa.gov

Attachment 6

HRSA Bioterrorism Hospital Preparedness Program

DELIVERABLE	HOSPITALS	EMS REGIONAL COUNCILS	STATE	TOTAL
Planning & Assessment	1,463,000	220,000	459,864	2,142,864
Hospital Equipment	390,554*			390,554
GRAND TOTAL	1,853,554	220,000	459,864	**2,533,418**

Hospital personal protective equipment, communications

CDC Public Health Preparedness and Response for Bioterrorism

REGIONAL/LOCAL CAPACITY	STATE CAPACITY	LOCAL HEALTH CAPACITY	CONTRACTS	TOTAL
Planning & Assessment (A)	1,910,599	3,466,100	27,481	5,404,180
Epidemiology & Surveillance (B)	676,098	3,291,530	1,436,028	5,403,656
Training (G)	455,187	1,345,960	27,324	1,828,471
TOTAL	3,041,884	8,103,590	1,490,833	12,636,307
STATEWIDE CAPACITY	STATE CAPACITY	LOCAL HEALTH CAPACITY	CONTRACTS	TOTAL
Laboratory (C)	1,068,204	270,710	911,395	2,250,309
Health Alert Network (E)	1,720,884	283,360	202,400	2,206,644
Communications (F)	394,295	437,006	197,340	1,028,641
TOTAL	3,183,383	991,076	1,311,135	5,485,594
GRAND TOTAL	6,225,267*	9,094,666#	2,801,968≠	18,121,901

Includes approximately $500,000 in laboratory equipment

[1]Includes PHIMS development, syndromic surveillance, laboratory renovations

#Includes some state direct purchase of equipment and system level resources for Local Health Jurisdictions

ASSESSMENT APPROACH FOR BIOTERRORISM GRANT

The following assessments are required or inferred in grant guidance:

Assessment Area	Comments - status
Hospitals	Much existing data. Not compiled. Meeting scheduled to bring data together; decide what more must be known to create standard assessment tool
EMS	Not required, but the information is important. Link with hospitals? Include law enforcement questions? Look at other sector assessments? Include some questions in the LHJ assessment?
Local Health	The major assessment activity. A tool is needed, based on prior tools – but containing only questions that are concrete and known.
Info-Tech – Local Gov.	Information needed from county staff. Questions are ready to disseminate. Can be done in a one day statewide meeting.
State Health Dept.	A tool is needed. Must parallel local tool.
Microbiology labs	Three questions; ready. Can be added to if we wish.
EMDs	Minimum: review plans in each county to see what currently exists. Use a checklist – enhanced from current list? Share information with LHJs. Also ask LHJs about county plan.
Training Needs & Capacity	Questions needed fro first assessment (local and state, above.) Should focus on capacity. Later tools should look to competency based needs assessment. Do that with UW and six states, using a standard tool.
Legal Issues	Analysis is very far along. We will call for local ordinances and review will be undertaken here by AGO. No need fro special assessment effort.

Major data sources to turn to for additional information
DOJ study for EMS, law enforcement, Hazmat… capacity and training issues.
Existing plans by county; ESF-8
Laboratory assessment

Models for Assessment

1. Standard Tools – for each of the following:

      Hospitals*   EMD
      LHJs*   IT
      States*   Labs

      *Committee for jointly developing tools

2. Synchronized timing

      State and LHJ tools synched to get to Regional meetings at same time

3. Interview (not just self assessment)

      Interviews on-site by regional coordinator, using tool provided ahead of time along with
          training or orientation to the tool

4. Electronic format (laptop ok)

      AAG to review legal protection needed for information collected through this process

      Data analysis plan worked out ahead of time, using standardized tool ,to allow ease in
          submitting and analyzing data.

5. Hospital – LHJ – Regional links

      Expect that hospital assessment will be completed first.
      Contracts should call for collaboration at local level.

Timing

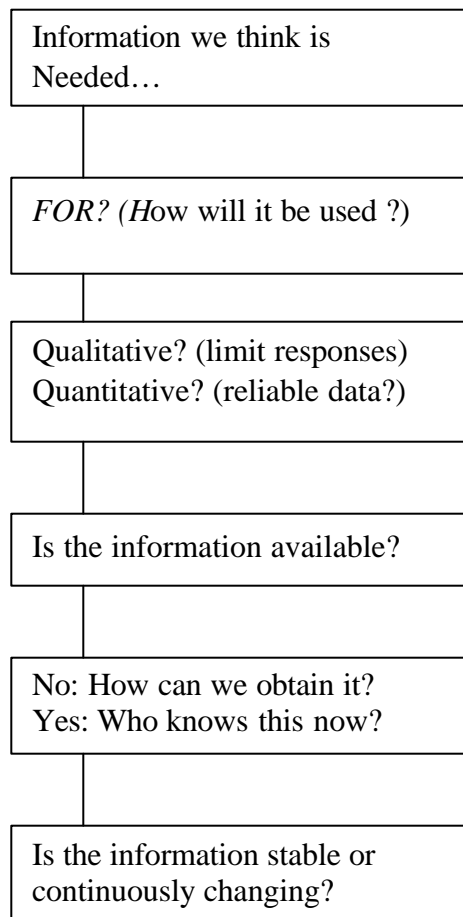|	
April 1	Develop tool
May 1	Test tool
June 1	Coordinators hired by June 1
	Train Coordinators to distribute and orient LHJs to tool
July 1	Administer tool
August 15	Collect and analyze data from mid-July to August 15
September 1	Disseminate reports to LHJs and Regions; write statewide analysis

Recommendation: allow 2 months for "slippage".

Assessment Tool Design
The tool should be carefully designed and tested. Questions should be developed only through rigorous attention to the ultimate use of the answers. All questions should be tested and the analysis plan completed before the assessment begins.

Information we think is Needed…

FOR? (How will it be used ?)

Qualitative? (limit responses) Quantitative? (reliable data?)

Is the information available?

No: How can we obtain it? Yes: Who knows this now?

Is the information stable or continuously changing?

General ideas to guide assessments:

Think of *phased* assessments – and communicate that need to the field.

Outline phases in advance to the extent possible.

Start with basics and go deeper as needed – at a later date.

Keep instruments simple, easy to complete.

Don't require repeated information

Seek a project coordinator from in-house and develop the tool using in-house resources.

Assessment Approach

Build on prior assessment Ask groups to complete a matrix like that shown below to be sure that all relevant data has been considered and that new questions build on but donot duplicate past questions.

Assessment Needed	Assessments Completed to Date – for *basic* information					
	Assessment	Epi	Lab	HAN	Comm.	Train.
Hospitals						
EMS						
EMD						
IT Assessment						
Local Health	PHEPA*					
State Health						
Micro Labs						
Training Needs						UW*
Legal Analysis						

* examples, only.

Data sources thought to be helpful
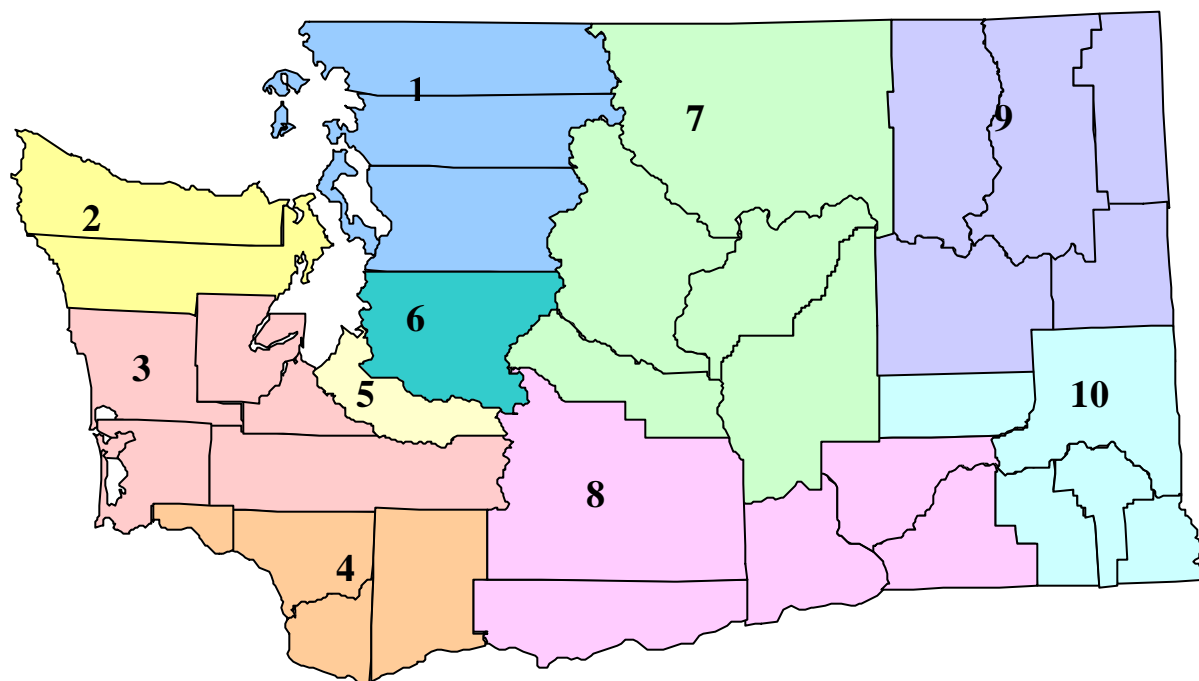> PHEPA
> Hospital data
> FEMA
> DOJ study for EMS, EMD, Law enforcement, HAZMAT
> > (training and capacity information)
> Laboratory assessment
> Existing plans, by county, ESF-8

Local Health Regions for Bioterrorism Planning and Coordination

Regional Composition:

No.	Lead Health Jurisdiction	Counties
1	Snohomish Health District	Snohomish, Skagit, Whatcom, Island, San Juan
2	Bremerton – Kitsap Health District	Bremerton-Kitsap, Clallam, Jefferson
3	Thurston County Health Department	Thurston, Lewis, Pacific, Grays Harbor, Mason
4	Southwest Washington Health District	Clark, Skamania, Cowlitz, Wahkiakum
5	Tacoma-Pierce County Health Department	Pierce
6	Public Health Seattle King County	King
7	Chelan-Douglas Health District	Chelan, Douglas, Okanogan, Grant, Kittitas
8	Benton-Franklin Health District	Benton, Franklin, Walla Walla, Yakima, Klickitat
9	Spokane - North Spokane Regional Health District	Spokane, Ferry, Stevens, Pend Oreille, Lincoln
10	Spokane – South Spokane Regional Health District	Whitman, Garfield, Columbia, Adams, Asotin

Letters of Endorsement

I.   FEDERAL, STATE AND LOCAL AGENCIES:
   a. Education
   b. Government
   c. Military
   d. Police and Fire

II.   LOCAL PUBLIC HEALTH
   a. Local health jurisdictions
   b. WA State Association of Local Public Health Officials

III.   HEALTH CARE ORGANIZATIONS
   a. Hospitals
   b. Laboratories
   c. Primary care clinics
   d. Physicians and nurses

IV.   EMERGENCY MANAGEMENT
   a. WA State Emergency Management Association